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

Why is Care Coordination Necessary?

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, 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] According to the National Quality Forum, "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 could result in $240 billion in annual healthcare savings."[2]

- Persons with severe mental illnesses experience diabetes, hypertension, and obesity at approximately 1.5 to 2 times the rate of the general population[3]
- Persons with serious mental illnesses are 53% more likely to be hospitalized for diabetes, which was manageable in an outpatient setting.[4]
- Persons with SUD have 9 times greater risk of congestive heart failure and 12 times greater risk of liver cirrhosis and pneumonia[5]

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 Effectiveness of Coordinated Care?

- Kaiser Northern California research found substance use treatment reduced costs by: 35% inpatient, 39% ER, and 26% total medical costs, compared to the control group.[6]
- SBIRT is feasible in various settings and effective reducing drug use (68%) and heavy alcohol use (39%) across gender, racial/ethnic, and age groups.[7]
- In TEAMcare, nurses worked with patients, their doctors and health teams to manage care for both depression and physical disease, resulting in less depression, and better control of blood sugar, blood pressure, and cholesterol.[8]
- 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.[9]
- CA county partnerships tested and implemented care coordination functions during several CiMH Learning Collaboratives with early results trending towards improved outcomes.[10]

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IBHP Integrated Behavioral Health Project

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How Can California Providers Adopt and Advocate for Care Coordination?

While national and State Level initiatives demonstrate the benefits of care coordination, California providers are struggling to fund care coordination for the safety net population. The Medi-Cal mental health 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 despite the evidence of better outcomes and lower costs for all systems, including hospitals and emergency departments. Medical systems, health plans (and emerging Accountable Care Organizations) are just beginning to recognize that care coordination for mental health, substance use, and chronic medical conditions is necessary to achieve quality outcomes and lower overall costs, including medical costs.

While there are challenges and barriers to large-scale implementation, counties and local provider organizations, and in some cases health plans, are forming partnerships to test care coordination strategies for high-risk populations. Pilots include testing the outcomes/effectiveness of models of care coordination, financing and re-investment of net savings, as well as performance improvement incentives.

Getting Involved: Demonstrating the effectiveness of care coordination for persons with complex conditions:

- Learn about and implement care coordination and care management within your organization, and track outcomes to demonstrate emerging team-based models including new workforce roles of peers and family members.[11]
- With Medi-Cal expansion, partner with health plans to address network adequacy issues, and improve access, care coordination, and care management for members with complex health and behavioral health conditions.
- Join MH/SUD and PC learning collaboratives to test and implement cost effective interventions.
- Contract with safety net health plans to participate in "Dual Eligibles" Medi-Medi demonstrations.
- Convene or participate in local/regional forums to explore care coordination and care integration and build partnerships with providers and payers
- Participate in technical assistance webinars sponsored by IBHP (IBHP.org).

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

[11] www.IBHP.org, www.CiMH.org, http://www.integration.samhsa.gov