Integrated Treatment In Kent County

White Paper

February 2011

"HEART OF THE CITY HEALTH CENTER," IN GRAND RAPIDS, MICHIGAN

This document was written by W. Paul Mayhue, Governmental Relations Coordinator employed by Touchstone innovarė with the assistance of Charles Spliedt, Cyndy Vairs and Linda Brauer, Touchstone is one of the three agencies that will work in the Heart of the City Health Center.

SETTING THE STAGE FOR INTEGRATED CARE

The Passage of Parity: Changing the Course of History!

The passage of the Wellstone –Domenici Mental Health Parity and Addiction Act of 2008 can be perceived as the foundation for integrated care. This law meant that insurance companies would have to pay for physical health and mental healthcare on an equal basis, if the employer or agency carried mental health insurance in their health insurance policy. Insurance companies could no longer discriminate against a person just because of their mental illness. However, this applied to companies with 50 or more employees; this left the smaller companies without coverage. There are positive, early indications that

relatively few employers dropped mental health coverage in 2010 in response to the law's mandate, which had been a concern of some of the bill's opponents.

Large companies with two hundred or more employees were found to be less likely than smaller companies to drop mental health coverage this year. According to a 2010 Employer Health Benefits Survey, (that the Kaiser Family Foundation and the Health Research & Educational Trust released in September), only 2% of employers of large companies dropped mental health coverage, compared to 7% of small companies. Furthermore, 75% of large firms eliminated mental health coverage limits, compared to 61% of smaller employers.

Assimilating Treatment of Physical and Behavioral Health Care Needs – Future Vision

The movement to pay closer attention to co-occurring disorders began to come forward in the middle 2000s. By the 2005 Touchstone Innovarė had created a team called Street Reach which made special effort to engage people with co-occurring behavioral and substance use disorders in this community. As a sitting county commissioner I took the bull by the horns and began to question the state, through the Kent County Commission, on its commitment to mental health. In 2006, we engaged the state of Michigan on producing a wellness and recovery model in this county. In 2007 our agency worked with State Representative Robert Dean's office to help define wellness and recovery. Through collaboration with Dr. Tom Blakely, we, defined a concept of wellness and recovery: "A Wellness and Recovery Model of treatment for a psychiatric condition organizes an integrated behavioral health service delivery system in which the client is informed and activated and works with a prepared and proactive practice team to achieve positive functional and clinical outcomes in the client's self-management of the condition that leads to recovery, a state in which the psychiatric condition is not a significant factor in how the client lives."

It was during the above time periods that I was assigned to work directly on the passage of Mental Health Parity in the State of Michigan. We as an agency knew through our experience of working with our clientele that we have to figure a way of independence for people with co-occurring disorders. As County Commissioner I had to create the public awareness of the problem of which I did by constantly bringing up the mental health issue on the county level. However, the mental health issue became broader than I expected, subsequently, I got permission from the Chairman of the Board to appoint a bipartisan Committee to work with me. Nadine Klein the Chairperson of the Mental Health Board in Kent County was the first volunteer. This was the beginning of the Kent County Mental Health Parity Discussion Group. Agency directors and other interested parties were recruited from the community; John Canepa, Retired Banker and Partner with Crowe Chizek Consulting Firm, Mark Eastburg, Executive Director of Pine Rest Hospital, Hank Fuhs, General Secretary of Michigan Republican party, Paul Ippel, Executive Director of network 180, Kevin Rose, Executive Director of the African American Health Institute, Khan Nedd, Board President of the African American Health Institute, Dr. Joseph Daniels of the African American Health Institute, Linda Brauer, Chapter Coordinator of CHADD, Madonna Saia, Grand Rapids Public Schools Nurse, Michael Reagan, President of the Behavioral Health Alliance in Kent County, Emily Quinn-Nausadis Director of Community Relations for Forest View Psychiatric Hospital, Barb Hawkins Palmer, Executive Director of Health Kent 2010, Joel Penny, Mental Health Foundation of West Michigan, Cyndy Viars, Disability Advocates of Kent County and Greg Dziadosz, Executive President of Touchstone

Innovarė, and Paul Mayhue, Commissioner for the 16th District and Governmental Relations officer for Touchstone Innovarė. This was the initial team that began this project

BRINGING PHYSICAL AND BEHAVIORAL HEALTHCARE TOGETHER

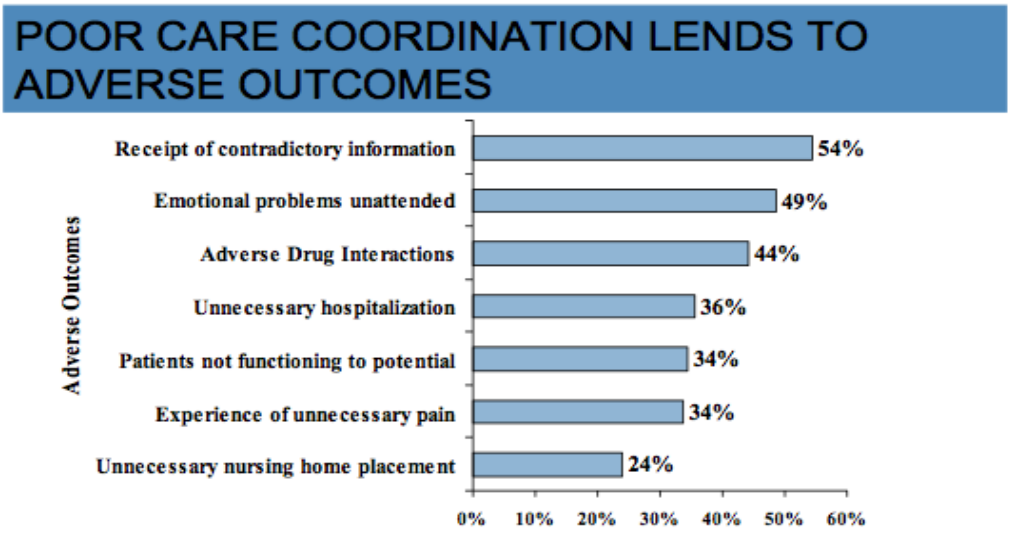
Reinventing Healthcare: Why Now?

With the current economic climate, and the aging of America, we can no longer use the acute care methods that have been acceptable in the past. The voting electorate requires more accountability in the use of tax based revenue. Business can no longer be "business as usual." The present economic environment should not be viewed as one of dire hopelessness, however, but as a reason to develop more effective, efficient methods for treating chronic health conditions.

The Need for a Chronic Care Model:

Our current healthcare system has been based on an acute care model in which a patient contacts their primary care doctor after there is a problem. Care is often provided during a brief office visit. Physicians do not have time to educate individuals about health and wellness, their condition, treatment options, or to provide monitoring and follow-up.

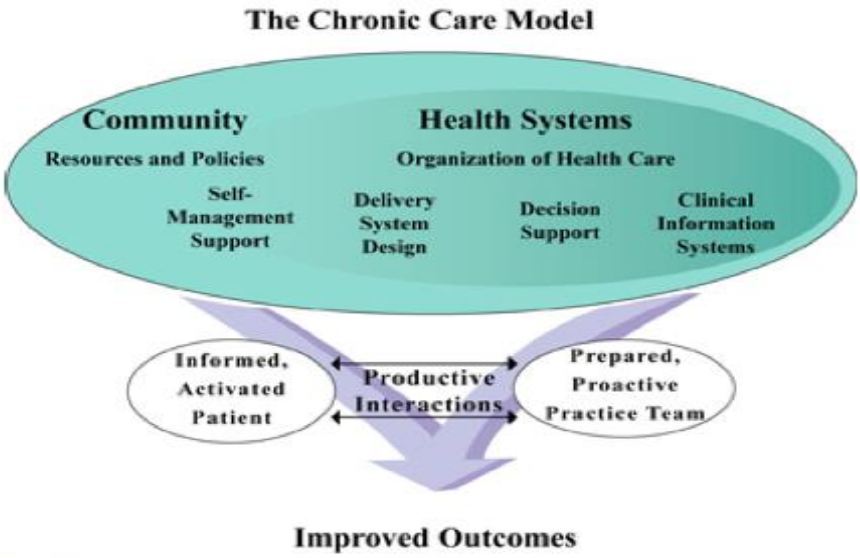
The Acute Care Model is reactive rather than preventive. Psycho-educational programs, education about nutrition and exercise, linkages to social services, support groups, smoking



Percent of Physicians Who Believe that Adverse Outcomes Result from Poor Care Coordination

Source: Partnership for Solutions, *National Public Engagement Campaign on Chronic- Illness – Physician Survey* conducted by Mathematica, Policy Research Inc., 2001. *Chronic conditions: Making the case for ongoing care, September 2004.*

cessation programs, and lifestyle management programs, are rarely included as part of treatment.



Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice. 1998;1(1):2-4.]*

Developed by The MacColl Institute © ACP-ASIM Journals and Books

Paradigm Shift: The Chronic Care Model of Treatment

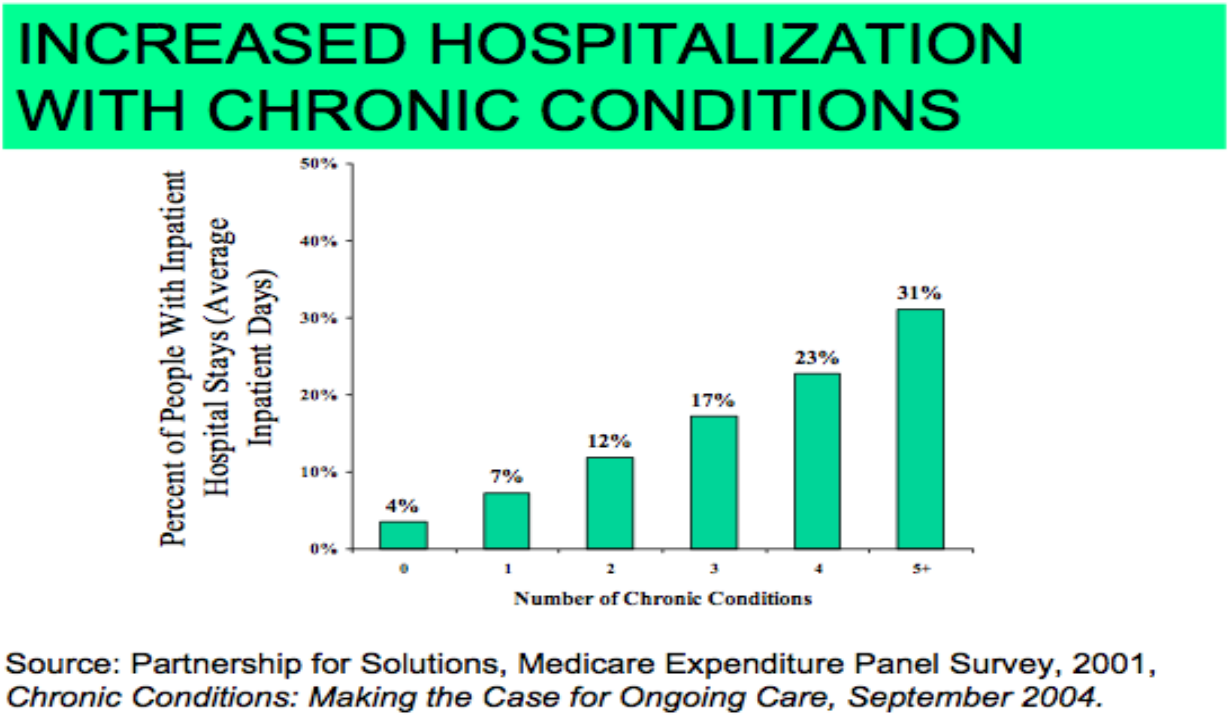
The current acute care model of treatment often results in fragmentation of care for individuals with chronic conditions. Our current healthcare system is historically based on an acute care model in which a patient contacts their primary care doctor when there is a problem. Care is provided during a brief minute office visit. Physicians do not have time to educate individuals served about wellness, their condition, or to provide treatment monitoring. It is often reactive

rather than preventive. Psycho-educational programs, education about nutrition and exercise, linkages to social services, support groups, smoking cessation programs, and lifestyle management programs, are rarely included as part of treatment and require that individuals

A diagnosis, alone, cannot indicate the degree of impairment, severity, disability, distress, risk, or disadvantage that an individual may be experiencing.

Treatment for specific disorders (that measurably improve with mental health treatment), have been excluded from coverage by some insurance plans because the company has determined certain diagnoses to be:

- **"Developmental,"** – to ideally be outgrown, or an –
- **"Education problem "** – that should be the responsibility of the schools to address, or a
- **"Behavior problem"** – that should be the responsibility of the juvenile justice system to



Source: Partnership for Solutions, Medicare Expenditure Panel Survey, 2001, *Chronic Conditions: Making the Case for Ongoing Care, September 2004.*

address.

- **In the Acute Care Model, the physician-patient relationship is directive, not interactive.** The physician is the expert and the individual receiving services must comply with instructions. Unfortunately, within 60 days, half of medications prescribed are not taken as directed, nor are 80% of diets and over 70% of exercise routines maintained. There is little attempt to build a relationship, and the recipient of services is not viewed as a member of the treatment team. In the

chronic care model, however, techniques such as motivational interviewing help people gradually take over responsibility for their own ongoing care.

- **In the Acute Care Model, doctors are paid to provide procedures, tests, and volume,** regardless of the necessity of the tests or the accuracy of their interpretation, and irrespective of patient outcomes. Often, emergency rooms become providers of universal health care. Emergency room visits are expensive, however, and are limited in being able to prevent a similar crisis from recurring.

Risks in Not Covering Certain, Specific Diagnoses

The Chronic Care model, which was developed by Wagner is ; a framework for producing healthy communities; a multi-dimensional solution to a complex problem; like an evidence-based guideline-a synthesis of system changes to guide quality improvement; intended to be flexible and subject to change when new evidence emerges. According to Paul Mayhue, Chair of the Kent County Mental Health Discussion Group, "the holistic treatment model of integrated treatment with mind, body and spirit is a fluid situation because one's body is always in a state of change and treatment has to adjust to where the person is at critical stages of change. The tragic situation for us all is that it is the insurance industry that determines what diagnosis out of the DSM that is paid; consequently, it is cost that drives treatment more than actual diagnosis. The Parity argument brought forth the fact that the profit motive should be taken out of treatment and that physical health and mental health should be paid for equally."

1. Cost to the Insurance Company:

A company may not realize that by not covering mental disorders, such as Post Traumatic Stress Disorder, Depression, Autism, AD/HD, or Anxiety, it can indirectly increase other costs, even though it may not immediately be evident on actuarial tables. Not covering a disorder can increase rates of unplanned pregnancies, accidental injuries, substance abuse, sexually transmitted diseases, smoking, serious motor vehicle accidents, and attempted suicide.

2. Cost to the Employer:

By excluding certain diagnoses, any initial savings must be subtracted from costs due to increased rates of employee turnover, accidental injuries, absenteeism, careless mistakes, substance abuse, having to pay unemployment benefits, family disruption, workman's compensation claims, low employee morale, and decreased productivity and efficiency.

3. Cost to Society:

Children with mental disorders, who cannot access appropriate mental health services, are sometimes removed from their families because of their parents' inability to keep them safe or monitor where they go, or protect themselves or their other children from harm. Tragically, however, if the problem is primarily because the child has not been able to access appropriate

psychiatric treatment, removing them from their family will not help. It can cause far more emotional instability in some cases.

Recently one child in Kent County, who had been receiving special education under "Emotionally Impaired," was suspended from school within two weeks of having been placed in foster care. Another child, who had been receiving special education services under "Emotionally Impaired," brought a gun to school after having been placed in foster care in Barry County, which he had never done before.

Not treating mental disorders in adult clients leads to unemployment, incarceration, financial and legal problems, loss of custody, and termination of parental rights, divorce, and substance abuse. It would seem that we should help people to be taxpaying citizens.

In a study funded by the National Institute of Mental Health in 2002, individuals with serious mental illness (those whose symptoms significantly impaired their ability to function for at least 30 days over the past year), earned 40% less than people without mental illness. On average, they earned $23,000 versus $40,000 a year, with many not having earned any money. This costs society 193.2 billion in lost earnings per year, not to mention the cost to society in the loss of Social Security payments, income tax, homelessness, and incarceration, according to Ronald Kessler, a Harvard professor of health care policy and lead author of the study. In a different study by Kessler, in 2005, 60% of Americans with a mental disorder had gotten no treatment at all. Short term but clinically diagnosable mental disorders such as depression and eating disorders were found to be the leading cause of disability in U.S. workers under age 45. http://www.time.com/time/health/article/0,8599,1738804,00.html

Eric D. Achtyes, MD, MS., Clinical Assistant Professor of Psychiatry, Michigan State University College of Human Medicine, Psychiatrist, Pine Rest CMHS and Touchstone Innovare, made a presentation on, "Why Medicine Needs Behavioral Health and Vice Versa," his thesis, "We can no longer afford to think of medical, psychiatric/psychological, and addictions as separate entities. By uniting medicine, behavioral health (mental health) and addictions in a medical home we can better address each of these problems in a multidisciplinary team designed to foster communications and cooperation between disciplines.

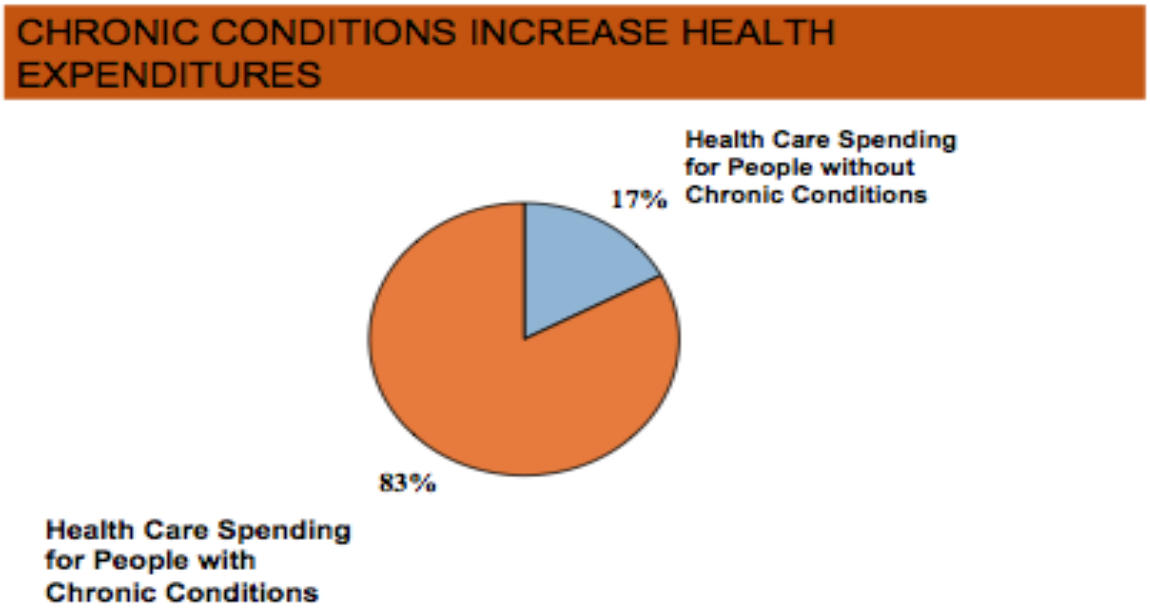
Addictions and psychiatric conditions have multiple overlaps; overuse of benzodiazepines for anxiety disorders and sleep aids resulting in addiction; alcohol and drug use resulting in depression and psychosocial dysfunction; use of cannabis and the development of schizophrenia; ECA Study: 45% of alcohol use disorders pts and 72% of drug use disorder pts had at least 1 psychiatric disorder; high level of co morbidity in: bipolar disorder, depression, ADHD, PTSD, schizophrenia, anxiety and personality disorders, according to the Am J Psychiatry 2005; 162: 1483-1493.

If Not the Cost...

In an article by Pat Schellenbarger, *(Chronicle News Service, January 24, 2008),* according to data by the MDCH, fiscal year 2006, it costs ten times more to confine someone in a Michigan state prison than to treat them for a mental disorder in the community. Mark Reinstein, the Director of the Michigan Mental Health Association in Michigan, has commented that we haven't de-institutionalized mental health treatment, we've trans-institutionalized it. Yet, no one worries about cost when someone is incarcerated. Now, being a "danger to yourself or others," is as likely to cause someone to enter the criminal justice system as the mental health system. It is apparently not just a matter of cost, then, but ideology, and political expediency.

Consequently, our system of jurisprudence has developed mental health courts, mental health units in our correctional systems. The Trans-institutionalization is like the transfer payments of the late 80s and early 90s where the poor was taken off Supplementary Security payments (SSI) and Transferred to State Disability Payment plans (SDA) of which after the transfer of payments was completed our homeless shelters began to fill up because the diagnosis were no longer eligible to receive benefits under the criteria of the federal government. Thus the poor had to take a reduced benefit and could not thrive and began to live in the streets and filled the homeless shelters, jails and prisons. Thus, the recidivism rates increased and some of the poor committed crimes just to stay warm in the winter and have a hot meal.

People with chronic conditions account for eighty-three percent of all healthcare spending. Nearly half of all Americans have at least one chronic illness. This is expected to increase as the population ages. Ninety-nine percent of Medicare spending is for individuals with at least one chronic condition and sixty-eight percent is for individuals with five or more chronic conditions.



Source: Partnership for Solutions, Medicare Expenditure Panel Survey, 2001, *Chronic Conditions: Making the Case for Ongoing Care, September 2004.*

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Health Care Reform: Since March 23rd, when President Obama signed the Patient Protection and Affordable Care Act into law, though there have been a number of challenges, there is also optimism. In September, the law allowed young adults to remain on their parents' insurance until age 26. It also prohibits lifetime limits. Beginning January 1st, Medicare will provide people with an annual wellness visit. Expanded Medicaid coverage will provide insurance coverage to an additional 32 million Americans who are within 400% of federal poverty limits, who previously had no coverage. By replacing state and local spending with federal dollars, states will save between 20 and 40 billion dollars due to the expansion of Medicaid. Laurel Stine, director of federal relations from the Bazelon Center for mental health law, said, "Health Care Reform is going to move us from parity to the expansion of Medicaid, to integrated care, to health care homes."

Regulators, insurers, and employers will need time to reach agreement on what new laws should allow and prohibit. Fortunately, however, many large employers are already close to providing equitable mental and physical health care benefits.

Making the Case for Integrated Health Care:

Many chronic physical disorders are associated with mental disorders. Rheumatoid arthritis and Parkinson's disease often co-occur with clinical depression, and some individuals with Obsessive Compulsive Disorder acquire it after having recovered from a strep throat. People taking psychotropic medications may need to monitor their blood sugar levels, thyroid, weight, or heart rate. Even the Diagnostic and Statistical Manual of Mental Disorders explains that the title should not imply that there is a distinction between mental and physical disorders.

Moving toward fully integrating treatment for chronic health conditions, both mental and physical, is a natural progression of providing equitable health care in which the whole person is treated, not just an illness. Rather than the Acute Care approach, that provides fragmented treatment through unrelated service providers, this is a holistic model integrating treatment of the mind, body, and spirit. It provides a multi-disciplinary approach for managing multiple, chronic health conditions in one location. Assimilating a chronic care model that integrates *behavioral* health, (mental health and substance use disorder), with *physical* health treatment, is "doctor driven" and "patient centered."

According to a study by the National Association of State Mental Health Program Directors in 2007, people with serious mental illnesses die an average of 25 years earlier than other Americans. Most die from preventable diseases such as asthma, diabetes, heart disease, cancer, and cardiopulmonary conditions. The study found that most of the people who had a serious mental illness were unable to access primary care settings. According to the Integrating Treatment in Primary Care Project, one third of individuals served, who have chronic illnesses, and who are readmitted to area hospitals within thirty days of their initial discharge, also suffer from depression and/or problems with addiction.

Though psychological issues are suspected in over thirty percent of visits to primary care physicians, only two percent are referred to a behavioral health specialist. Up to seventy percent of depressed individuals seek treatment solely from Primary Care Physicians *(Hoffman, Rice, & Sung, 1996).* It was determined that one reason physicians don't refer patients is that most individuals don't want "extra help." They worry about mental health stigma or having to go to another set of appointments with another set of professionals. They want to get behavioral health services within the context of "normal" health services.

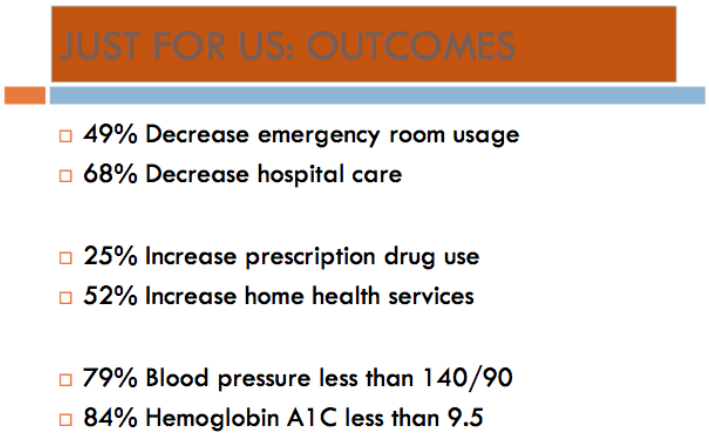
Schizophrenia can be frightening, but it doesn't have to determine quality of life. With medication, therapy, and support, many people with schizophrenia are able to control their symptoms, gain independence, and lead fulfilling lives. Early diagnosis and treatment can prevent many unnecessary complications and increase the chance of recovery. This alone makes the case for Integrated Treatment and the direction of the Heart of the City Health Clinic and the use of the medical home programs. Bringing the Chronic health problems under one

roof helps to de-stigmatize treatment, and neutralize a person's is going to mental health treatment program.

Coming "Home"

- The concept of having a "personal medical home" was first conceptualized in 1967.
- In 1992, the American Academy of Pediatrics published a policy statement.
- In 2002, the definition became operationalized. Seven United States family medical organizations started the Future of Family Medicine Project to renew the specialty of family medicine. They recommended that every American have a personal medical home through which to receive acute, chronic, and preventive healthcare. They wanted services to be patient centered, safe, accountable, accessible, comprehensive, integrated, and scientifically valid to both patients and their physicians.
- One study, in 2004, estimated that if their recommendations were followed it would save 5.6% in costs, resulting in a national savings of 67 billion dollars per year with overall, improved health outcomes.
- In 2006, a Patient Centered Primary Care Collaborative was started with the help of IBM and other businesses.
- In 2007, a number of medical professional organizations, including the American Osteopathic Association, released the Joint Principals of the Patient Centered Medical Home. In addition to the principals already mentioned, they recommended that care be coordinated or integrated across specialties, hospitals, home health agencies, and nursing homes. Increased access would be provided through open scheduling, expanded hours, and new options for communication.
- In 2007, a survey of 3,535 of adults in the US found that 27% of respondents, who had four of the indicators of having a medical home, experienced improved access to care, more preventative screenings, higher quality of care, and experienced fewer racial and ethnic disparities.
- In 2009, 20 bills were introduced in 10 states to promote medical homes.
- In 2010, seven health information technology domains were determined necessary for success: telehealth, measurement of quality and efficiency, care transitions, personal health records, registries, team care, and clinical support for chronic conditions."
- Other research found medical homes to be associated with fewer medical errors and duplication of tests.
- In 2010, Reid, et. al., in Seattle, found medical homes to be associated with 29% fewer Emergency Room visits, 6% fewer hospitalizations, with a total savings of $10.30 per patient per month, over a 21 month period.
- In 1994, Brazil launched one of the largest community based primary health care programs in the world. Each team consists of one physician, one nurse, a medical assistant, and and four to six trained community agents. They additionally make regular home visits and conduct neighborhood health promotion activities. During 1999-2007, in Brazil, communities with high *Family Health Program* enrollment, **chronic disease hospitalization rates were 13% lower than in municipalities with low enrollment, when other factors were held constant**

(*"Confronting the Chronic Disease Burden in Latin America and the Caribbean" Health Aff, Millwood, December 2010 29: 2142-2148)*



"Just for Us" is a voluntary, fee-for-service program that provides case management, primary care, and mental health services. It has multiple agencies under one umbrella, and treats individuals who have been unable to obtain a primary care provider. 58% of individuals treated had hypertension and took an average of 5 medications. 45% had diabetes, and 44% had a mental health diagnosis.

Reducing Stigma in Grand Rapids, Michigan:

During an interview, Oct. 5, 2010, with Dr. Greg Dziadosz, President of Touchstone *innovarė* in Grand Rapids, he explained that historically, institutionalization created stigma, and that separating mental health funding from physical health funding has increased stigma over the past century. He said that the Western Mental Health Foundation, a wholly owned subsidiary of Touchstone innovarė was founded to educate the community about mental health and to combat stigma. He said that integrating care, so that people seeking behavioral health services are not segregated from those seeking physical health services, will reduce stigma. He feels that having more stringent privacy laws for behavioral health than for physical health has increased stigma, as if there must be some reason to be "especially afraid" of people with mental illness or substance use disorders. Dr. Dziadosz said, "That originally it was fear that caused mental health to be taken out of medical health care, but now it is medical health care that wants behavioral health care to again be included." He said that integrated care provided at the upcoming "Heart of the City Health Care Center, will not provide stratified mental health services requiring people to have to "fail first" to become eligible for a specific level of care. People won't be categorized as "outpatient clients," "case managed clients," or "A.C.T. clients." The medical home model that the Heart of the City Health Care Center will promote will revolutionize care to defuse stigma.

Through the use of "medical homes," everyone will be assigned a Primary Care Physician to coordinate and individualize their care. He said people will be provided treatment based on their unique needs, in a seamless, expanded system, in which members of the treatment team will work together to optimize treatment and provide follow up. Having an individual's treatment team meet together, once a week, had proven successful in a pilot program. In a demonstration case, he explained that a Touchstone client hadn't been taking his antipsychotic medications, because he felt they weren't effective. The treatment team discovered that the individual's blood sugar levels needed to be adjusted. Afterward, the client stated that he had never felt better. Ideally, integrated care will bring behavioral health and medical health care together, as well as communities.

Demonstrating Outcomes:

Accurate, complete, clear, and consistently collected data, available to all members of an individual's treatment team, will be instrumental in demonstrating the effectiveness of integrated health care. The *Health Information Technology for Economic and Clinical Health Act of 2009, (the HIGHTECH Act)*, provides reimbursement incentives for eligible professionals and hospitals that can demonstrate meaningful use of electronic health records, that establish standards, specifications, certification criteria, and that protect privacy and security.

Electronic Health Records, as defined by the *Health Information and Management Systems Society* is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included are demographics, progress notes, problems, medications, vital signs, medical history, immunizations, laboratory data, and radiology reports. It can interface with evidence based decision support, quality management, and outcomes reporting. It is expected to track service delivery, cost per service unit, retention rates, and service utilization rates. Electronically integrating physical and mental health care records will facilitate interdisciplinary communication between service providers.

Accurate and consistent data will be a deciding factor in defining the success of the integrated health care. Collected consistently, reliable, valid, complete and accurate data can demonstrate the benefits of the holistic integrated model.

Efficiency measures can track service delivery cost per service unit, retention rates and service utilization. There is built in efficiency in integrating both the physical and mental health care records.

Effectiveness is determined by measuring change over time in areas such as: maintenance of abstinence, community integration, reduction or elimination of incidence or relapse, reduction or elimination of negative involvement with the criminal justice system, improvement in physical health, reduction in frequency or length of hospitalizations, reduction of symptoms, improvement in psychological functioning, and reduction in frequency of interventions.
Recovery indicators can include improved functioning based on employment, relationships, housing, finances, and gaining or regaining the role of student, worker, community member, or tenant. Other indicators of quality of life include symptom control or reduction, improved health, and an increased sense of empowerment, well being, personal responsibility, autonomy, affiliation, self determination, community participation, efficacy, social inclusion, self worth, connectedness, identity, meaning, purpose, hope, and optimism.

Regarding **access** to services, the convenience of providing multiple services at one site, in close proximity to emergency care, and the success of having uniform referral mechanisms, will lead to better outcomes and increased rates of client satisfaction.

Satisfaction is determined by feedback provided by recipients of services, family members and significant others, personnel, the community, and funding sources. Satisfaction outcome measures determine the degree of the client's feeling of hope, whether or not the client felt they were treated with dignity and respect, whether services were culturally sensitive, whether individuals were informed about their choices and different modes of treatment, and were provided follow up, referrals to support groups, or training on their continued care.

The ONC, the *Office of the National Coordinator for Health Information Technology*, was created in 2004, and is responsible for coordinating nationwide efforts to promote the electronic exchange of health information, under the Department of Health and Human Services. The present National Coordinator is David Bluementhal, M.D., M.P.P. The first stage of implementation begins in 2011, and will occur in three stages, ending in 2015.

Involving Stakeholders:

Stakeholders are individuals or groups who have an interest in the activities and outcomes of this process of holistic service delivery. They include, but are not limited to, the individuals served, their families, governance, purchasers, regulators, employers, referral sources, unions, advocacy and support groups, insurance companies, landlords, business interests, and the community. Involving stakeholders entails gathering input through a variety of mechanisms to collect information to promote ongoing quality improvement. By involving individuals receiving services, they become valued partners in their own recovery and can use their experience to help others. It is not like the paternalistic approach in which someone is the expert and patient input is not sought. Particularly with older adults or people with complex conditions, whose baseline may fluctuate, or for whom a change in treatment can cause a cascade of unintended consequences, it is important to include the individuals and members of their treatment team. "Nothing about me without me."

"HIP HOP for Mental Health Parity"
A community outreach sponsored by the Kent County Mental Health Parity Discussion Group on October 4, 2009 to promote mental health parity and encourage youth to seek help for mental health or substance use disorders.

Public Education

Meetings sponsored by the Mental Health Parity Discussion Group

We, as a group began to educate the public about the need to look at the future of mental health and health care. Our concept of Integrated Health Care at Its Best-Mental Health Parity/ Implementation Phase brought together in 2008 and 2009 over 300 community leaders, healthcare professionals, political leaders, and consumers that gathered at the Women's City Club and Meijer's Gardens to discuss the critical issues of health integration and parity in Kent County by having table top discussions. The Hip Hop for Mental Health session at Rosa Parks Circle in Grand Rapids, Michigan brought awareness to a generation of young people in our community. Initially we were concerned about the passage of mental health parity on the state level but after the passage of the Federal 2008 mental health parity law, we switched our focus to integrated treatment specifically. We, in 2009, were able to bring in Blue Cross/Shield Blue and Aetna representatives to help us understand their side of the integrated treatment paradigm. We produced White Papers after each community event, those white papers were sent to all of the United States Congress, State of Michigan Legislature, County Health Boards, all of the people that were represented at the meetings and released to the state and local media. This was a major branding campaign for Integrated Health Care and the future of positive treatment for our clientele and the community in general. One of our very special moments was on October 3rd 2009 we held a HIP HOP for mental health event. This event was very heavily and favorably publicized by the local media. Our outreach to the youth of this community through the Hip Hop movement is paying dividends, several events surrounding the Hip Hop generation have been put on in this community. Our desire to reduce stigma and give youth the cover to discuss and seek mental health care has began to multiply, by working with youth in our community gives the concept of integrated treatment longevity and voice beyond our life time.

POTENTIAL PROBLEMS AND CONCERNS

"Is This A Gatekeeper Model?"

There has been skepticism about how Integrated Care would differ from managed care's use of Primary Care Providers as gatekeepers who can profit by **not** referring individuals to specialists. According to Bradley Timms, of "eClinicalWorks" Electronic Health Records, in Georgia, the initial move toward integrated care was motivated by doctors coming together who no longer wanted the standard of care to be determined by insurance providers.

The integrated care model is driven by ACOs (Accountable Care Organizations). Providers sharing responsibility for patient outcomes are rewarded. ACOs are viewed as part of a comprehensive strategy intended to influence provider training and attitudes, and the number

and mix of providers. However, if providers are to be paid on a performance or outcome basis, there needs to be a way to protect individuals from providers who don't want to treat individuals who have complex or chronic conditions, or who may be deemed "non-compliant."

Unlike the gatekeeper model, in a medical home, a patient has open access to see any physician they choose within the system. No referral is required. Instead of profiting by not providing care, the medical home model rewards quality, patient-centered, collaborative care.

If Funding Falls Short:

It is expensive to provide integrated care, but there are federal funds available, some as soon as January, 2011, under Health Care Reform, for clinics that provides personal Medical Health Homes (for people dealing with more than one chronic condition.) However, if we fail to secure the funding necessary to provide expanded services and incentives that promote collaborative, patient-centered care, or "meaningful use" of Electronic Health Records, there is concern that the model will not have the funding necessary to provide the seamless service delivery system associated with improved outcomes at decreased costs. Individuals need to be able to access "therapy," psychiatrists, psychologists, therapists, and auditory and visual care specialists. If there are too few funds to provide expanded care, however, and the Primary Care Provider must provide all services, there is concern that we won't have mental health services, after all, even if they are covered.

Some things to conclude are:

1. There are many mental disorders, such as Schizophrenia, Bipolar Disorder, Depression, Attention Deficit/Hyperactivity Disorder, Autism, Post Traumatic Stress Disorder, and Anxiety Disorder that go untreated in children and the young adult population. Rosalynn Carter in her book *Within Our Reach,* wrote*:*

"Mental health problems in children are about as common as broken bones, and in many cases, as easily addressed. Our failure to treat these problems appropriately has devastating consequences. I have seen adolescents thrown out of school and put in prison when what they needed was help. I have talked to parents who have had to turn their daughter over to the state in order to get treatment. I have shared the pain of a father who lost his son to suicide"

2. The National Institute of Mental Health states, "One in four adults, approximately 57.7 million Americans experience a mental health disorder in a given year." Profit should not be the priority. Health needs to be more important than creating wealth.

3. The concept of equitable benefits in implementing mental health parity requires that we cannot exclude a particular diagnosis. The mental health parity movement does not single out one diagnosis over another, such as Autism or AD/HD. All brain disorders are equally important. Chronic illness impacts not only the individual, but the family, friends, and the larger community. We need to go beyond traditional paradigms of treatment. Our correctional facilities and homeless shelters are full of individuals who, along their life's journey, were not afforded comprehensive, appropriate treatment. The practical imperative of moving forward in the direction of fully integrating the treatment of chronic conditions, promises to produce positive outcomes, reduce costs, and help individuals find a medical "home."

4. There is another group of individuals we must be sure have their mental health needs appropriately addressed, --our returning veterans. The military has led the way in researching emotional trauma, but there is still much to learn. Though previously we may have always called conditions resulting from exposure to threat of death, serious injury, or threat to physical integrity, ---"combat fatigue" or being "shell shocked," twenty five years ago most clinicians did not know what "Post Traumatic Stress Disorder" was. In the period following World War II, PTSD began to broaden to include not only combat-related stress but also "reactions in response to overwhelming environmental stress 'outside the range of usual human experience." The military uses the term Critical Incident Stress Disorder/Management since the goal is to identify an ASR (Acute Stress Reaction) or ASD (Acute Stress Disorder) before it becomes PTSD.

In spite of the mental health stigma found in the general population, there is far more in the military. "We are taught to push through the pain, whatever it is, and to SUCK IT UP!"

There seems to be estimates of rates of prevalence of PTSD in returning veterans of around 35%.

As of July 12, 2010, new regulations are making it easier to be diagnosed with PTSD which will be helpful to many, including those whose records have been damaged and for women whose records may not show they had combat assignments, even though their roles placed them where there was hostile military or terrorist activity. This is made possible because the VA proposes making Veterans Integrated Service Networks (VISNs) to develop plans for distributing the funds to ensure adequate funding at sites based on number of claims being processed to determine their regional needs. It appears that the military, also, is creating medical homes.

RECOMMENDATIONS

There is a variety of ways that legislators, organizations, service providers, and individuals can demonstrate their support for the integrated health care model. These include:

- Encouraging one's employer to provide a behavioral health (Mental Health) insurance benefit.

- Encouraging the coverage of the behavioral health benefit to provide the same degree of coverage as the physical health care benefit.

- Recommending that no diagnosis be excluded, such as PTSD, Autism, anxiety, or AD/HD.

- Encouraging the use of a health benefit that promotes a healthy life style, to prevent or minimize the impact of having a chronic condition.

- Encouraging that the behavioral health interventions have demonstrated effectiveness.

- Encouraging universal access to health care. In support of this effort, Heart of the City Health Clinic in Grand Rapids, Michigan, will write a letter to Elected Officials.

- networking and streamlining of service delivery models with like providers such as the traditional Community Mental Health and the Veteran's Administration

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Appendix A. Community Involvement

The Kent County Mental Health Discussion Group would like to thank the participants of the discussion that took place in October of 2010 at the Women's City Club. The type of co-operation and commitment to positive change in our community sheds light on how we in Kent County work together. The Integrated Treatment Model is a powerful and useful tool in helping to further de-stigmatize treatment for mental health and substance use disorders. This list includes only those participants that signed in and gave resources, thank those that did not sign in as well.

- Donna Abbot, Bethany Christian Services
- Erika Arndt, Student, Grand Rapids Community College
- Laurie Arnswald, Student, Grand Rapids Community College Nursing
- Tom Blakely, Retired Professor, Western Michigan University
- Arlene Brandt, Arbor Circle
- Linda Brauer, CHADD
- Nadia Brigham, Kellogg Foundation
- Donald Bryant, Bryant Health Care Solutiions
- John Canepa, Retired Banker
- Mary Cary, Student – Mental Health Nursing
- Ross Cate, Kent Intermediate School District
- Cleo Corliss, Touchstone Innovare
- Sally Cory, Kent County Health Dept.
- Patricia Dalton, Kent County Medical Society
- State Representative Robert Dean
- Maria Del Carmen Cruz, Spectrum Health Programa Puente
- Kathleen Delp, Private Practice

- Janis DeVree, Senator Mark Jansen's Office
- Dr. Duane DiFranco, MD, Blue Care Network
- Greg Dziadosz, Touchstone Innovare
- Mike Faas, Metro Health
- Lindsay Farah, Student-Mental Health Nursing
- Daniel Fogel, Life Guidance Services
- Brittnie Finkbeiner
- Hank Fuhs, General Secretary of Republican Party
- Andrea Goodwin, Student-Mental Health Nursing
- Carlene Grassmid, Dwelling Place Housing
- Jack Greenfield, Arbor Circle
- Josh Hagedorn, Hope Network Behavioral Health
- Cory Hanna, BRAINS
- Nancy Harper
- Barb Hawkins-Palmer, Healthy Kent
- Paul Hedg-Peth, Catholic Charities of West Michigan
- Angela Helder, Student –Nursing Mental Health
- Trillium Hibbeln, Helen DeVos Children's Hospital
- Therran Hines, Mental Health Foundation of West Michigan
- Vern Hoffman, MICAH Center of Western Michigan
- Jeff Hollander, Grand Rapids Housing Commission
- Andy Hotaling, Forest View Psychiatric Hospital
- Pat Howe, Hope Network Behavioral Health
- Hope Huizinga, Gerontology Network
- Nan Hunt, Spectrum Health- Care Management
- Paul Ippel, Network 180
- Richard Liberatore, Heart of West Michigan United Way
- Jessica Livingston, Student-Mental Health Nursing
- Shawn Malee, Goodwill Reach
- Neville Marks, Network 180
- Ted Masterton, Touchstone Innovare
- Paul Mayhue, Touchstone Innovare
- Joseue Melendez, Kent Health Plan
- Scott Miles, Forest View Psychiatric Hospital
- Amy Miller, Goodwill Industries
- Joel Mindes, Holland Hospital
- Carrie Mull, RN, Saint Mary's Health Care
- Dorothy Munson, Community Resource Connection
- June Nganga, Student-Mental Health Nursing
- Carlos Pava, Voices for Health
- Joel Penny, Mental Health Foundation of West Michigan
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