

June 18, 2010

U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 736-E  
Washington D.C. 20201  
Attention: MCC Strategic Framework

To Whom It May Concern:

The National Council for Community Behavioral Healthcare (National Council) is pleased to respond to the Department of Health and Human Services’ (HHS) **Strategic Framework for Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions 2010-2015**.

The National Council, a non-profit association representing over 1700 community mental health centers and other community-based mental health and addiction providers, is dedicated to fostering clinical and operational innovation and promoting policies that ensure more than 6 million low-income children, adults, and families our members serve have access to high quality services. Community mental health and addiction organizations have more than 40 years of experience and expertise in providing a range of clinic-based services and recovery supports for some of the nation’s most vulnerable citizens. Community mental health and addiction organizations are essential to the very fabric of the nation’s health care safety network and coordinate care for millions of individuals with multiple chronic health problems.

Mental illness and substance use disorders are chronic diseases that are prevalent, costly and frequently co-occur with other physical chronic conditions, thereby complicating the course of these diseases and resulting in poorer health outcomes, as demonstrated by Figure 1.

Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular	Gastrointestinal	10.2%	27.8%
Central Nervous System	Pulmonary	7.0%	26.2%
Cardiovascular	Renal	7.1%	24.6%
Pulmonary	Gastrointestinal	5.9%	24.2%
Psychiatric	Gastrointestinal	9.5%	24.0%

Figure 1. Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data<sup>1</sup>

Furthermore, individuals with substance use disorders can cause or exacerbate other chronic health conditions. Substance use disorders tend to co-occur with other chronic diseases such as hypertension, asthma, heart disease, or disease of the pancreas. In addition, individuals with severe mental illnesses experience high morbidity and mortality rates. As an illustration, a series of recent studies consistently show that persons with serious mental illnesses who are clients of the public mental health system die sooner than other Americans, and have an average age of death at 52.

<sup>1</sup> Kronick, R. G, Bella, M. & Gilmer, T. P. (2009). *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies, Inc. <[http://www.chcs.org/usr\\_doc/Faces\\_of\\_Medicaid\\_III.pdf](http://www.chcs.org/usr_doc/Faces_of_Medicaid_III.pdf)>.

Through the efforts of the strategic framework, the National Council sees the Centers for Medicare and Medicaid Services (CMS) moving from a financier to an innovator. Innovation is important in creating coordinated health homes as well as to expanding grant program opportunities. When developing protocols for care coordination, it is cost-effective to maximize existing resources that have expertise in helping individuals with multiple chronic conditions manage and improve their overall health, such as behavioral health services provided by community behavioral healthcare organizations. Given the high rates of Multiple Chronic Conditions (MCC) in the severe mental illness and substance use population, we trust that the Department of Health and Human Services will make efforts to address the needs of these individuals within the strategic framework and provide the following specific commentary.

**Goal 1: Provide better tools and information to health care and social service workers who deliver care to individuals with MCC**

It is crucial to identify tools and information that can better serve individuals with MCCs in the mental illness or substance use disorder population. A Massachusetts study identifies the complexity of the MCC population and reports that 60% of individuals with schizophrenia die due to other medical complications such as cardiovascular, pulmonary and infectious diseases.<sup>2</sup>

**Objective A: Identify Best Practices and Tools**

The heterogeneous client mix makes it necessary to consider such aspects as Medicare/Medicaid populations, dual eligibility, economic status, and specific cognitive impairments, in order to effectively treat clients with MCCs. There has clearly been Congressional recognition of the implications of these issues. The Guidance, Understanding, and Information for Dual Eligibles (GUIDE) Act of 2009 (H.R. 2390) and the Patient Protection and Affordable Care Act (PPACA) both include provisions that acknowledge the needs of individuals with complex conditions. A 2006 Maine Health Study indicates the prevalence of severe mental illnesses within the Medicaid population. Figure 2 illustrates the prevalence of Medicaid beneficiaries with severe mental illness in combination with other health disorders.

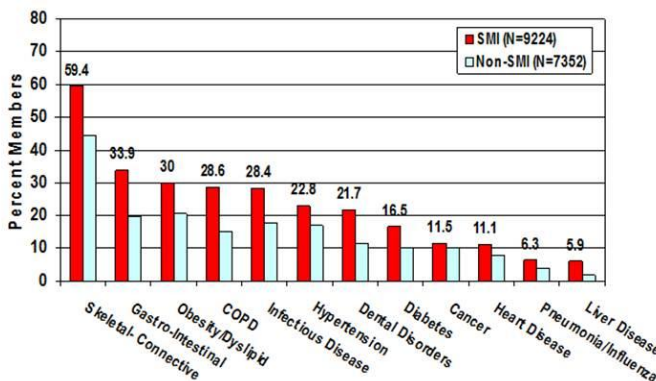


Figure 2. Comparison of Medicaid Beneficiaries with and without a Severe Mental Illness (SMI)<sup>3</sup>

<sup>2</sup> Parks, J., Svendsen, D., Singer, P. & Foti, M. E. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. National Association of State Mental Health Program Directors.

[http://www.nasmhpd.org/general\\_files/publications/med\\_directors\\_pubs/technical%20report%20on%20morbidity%20and%20mortality%20-%20final%2011-06.pdf](http://www.nasmhpd.org/general_files/publications/med_directors_pubs/technical%20report%20on%20morbidity%20and%20mortality%20-%20final%2011-06.pdf).

<sup>3</sup> Freeman, E., Yoe, J.T. (2006) *The Poor Health Status of Consumers of Mental Healthcare: Behavioral Disorders and Chronic Disease*, Presentation to National Association of State Mental Health Program Directors Morbidity and Mortality Workgroup. [http://www.nri-inc.org/conferences/Presentations/2008/06a\\_FreemanIntro.pdf](http://www.nri-inc.org/conferences/Presentations/2008/06a_FreemanIntro.pdf).

The figure also illustrates the importance of coordinated care. According to Alakeson and colleagues, “people with severe and persistent mental disorders are generally poor and reliant on public disability benefit payments.”<sup>4</sup> Poor individuals are likely to experience poor living conditions, and a limited supply of healthy food options which would create other medical complications and potentially result in multiple chronic conditions. Due to a significant variety of MCC clients, it is necessary to identify best practices and tools to better address their overall health needs. Because community behavioral health organizations often see many Medicaid clients and dual eligible beneficiaries, they have an opportunity to serve an important function and coordinate care within this population.

### **Objective B: Enhance Health Professionals Training**

Enhancing training programs for health professionals is crucial in the ever-changing health industry. The Patient Protection and Affordable Health Care Act addresses the enhancement of health professional training with the funding of HHS educational grants, the Primary Care Extension Program, and the National Health Service Corps. The National Council recognizes the importance of educational programs within community behavioral healthcare and encourages targeted outreach to support behavioral health and primary care providers in recruiting and retaining clinicians.

In addition, we encourage the promotion of programs, like Mental Health First Aid (MHFA), that utilize evidence-based training to educate a broad range of medical and front line staff about mental illnesses and substance use disorders. A 2004 study of MHFA found that 78% of the surveyed course participants encountered a mental health related situation and were able to use the skills taught within the MHFA training program. In addition, participants increased their empathy and confidence throughout the course and became more capable of handling a crisis situation.<sup>5</sup>

### ***Goal 2: Maximize the use of proven self-care management and other services by individuals with MCC***

#### **Objective A: Facilitate self-care management**

Similar to other chronic conditions, self-care management programs are an effective way to treat individuals with mental illnesses and/or substance use disorders. Georgia has implemented a peer specialist program in order to reach out to the behavioral health community. According to Sabin and Daniels, “the certified peer specialist role is the fulcrum of Georgia’s effort to manage its services for person with serious and persistent disorders in a manner that promotes consumer-friendly recovery values.”<sup>6</sup> Other states have incorporated training programs to combat mental illnesses and substance use disorders. The UPenn Collaboration on Community Integration reports that the peer training program in Arizona “is an excellent opportunity for people with psychiatric experiences to take charge of their own recovery and then give back to their community by helping individuals do the same.”<sup>7</sup>

<sup>4</sup> Alakeson, V., Frank, R. G. & Katz, R.E. (2010). *Specialty Care Medical Homes for People with Severe, Persistent Mental Disorders*. Health Affairs. <<http://www.psych.org/Departments/HSF/CHSF/Health-Affairs-Medical-Home-for-SPMI.aspx>>.

<sup>5</sup> Jorm, A. F., Kitchener, B. A. & Mugford, S.K. (2005). *Experiences in apply skills learned in a mental health first aid training course: a qualitative study of participants’ stories*. BMC Psychiatry. <<http://www.biomedcentral.com/content/pdf/1471-244X-5-43.pdf>>.

<sup>6</sup> Sabin, J.E. & Daniels, N. (2003). *Managed Care: Strengthening the Consumer Voice in Managed Care: VII. The Georgia Peer Specialist Program*. Psychiatric Services. <[http://www.files.georgia.gov/DHR-MHDDAD/DHR-MHDDAD\\_CommonFiles/15497224Georgia\\_s\\_Peer\\_Specialist\\_Program.pdf](http://www.files.georgia.gov/DHR-MHDDAD/DHR-MHDDAD_CommonFiles/15497224Georgia_s_Peer_Specialist_Program.pdf)>.

<sup>7</sup> Katz, J., Sakzer, M. & University of Pennsylvania Collaborative on Community Integration. (2006). *Certified Peer Specialist Training Program Descriptions*. <<http://www.upennrrtc.org/var/tool/file/33-Certified%20Peer%20Specialist%20Training%20-%20PDF.pdf>>.

The consumer community has encouraged self-care management within the behavioral health community. The peer specialist training at the Depression and Bipolar Support Alliance (DBSA) prompts similar strategies as to those within Georgia and Arizona, but also provides training opportunities to specific audiences such as veterans and faith based communities in order to accommodate to multiple health needs within the population.<sup>8</sup>

### **Objective B: Facilitate in-home and community-based services**

The establishment of the National Health Care Workforce Commission under Section 5105 of the Patient Protection and Affordable Care Act will help to reduce barriers to improve coordinated care. In addition, the National Council encourages other programs such as Mental Health First Aid in order to facilitate support within in-home and community-based services.

### ***Goal 3: Foster health care and public health system changes to improve the health of individuals with MCC***

### **Objective A: Improve care coordination through introduction of proven and potentially effective patient care management models**

In order to improve care coordination for individuals with mental illnesses or substance use disorders, it is necessary to consider the state's flexibility and the role of Medicaid and Medicare demonstration programs. Recent health legislation, Section 3502 of the PPACA, establishes the creation of medical homes that include "comprehensive, community, and coordinated care." In addition, Section 2703 authorizes Medicaid beneficiaries with chronic conditions to enroll in medical homes. For individuals who experience MCC within the mental illness and substance use population, the combination of primary care and behavioral health services are crucial to identify the specific needs of the client. In Tennessee, the Cherokee Health System "employs behavioral health consultants, usually psychologists, to support primary care providers in treating mild-to-moderate mental health conditions and help them with the behavior-change aspects of chronic disease management."<sup>9</sup> The integration of mental health and substance use care with primary care would provide effective patient care management models for MCC clients within the behavioral health population.

### **Objective C: Develop Provider Incentives**

Due to the high rates of MCCs within the mental illness and substance use population, it is important that these individuals obtain effective models of care, such as specialized services, to treat their health needs. Through specialty Managed Behavioral Health Organizations (MBHOs), providers are able to combine the payment for outpatient services and acute inpatient services. Currently, Institutions for Mental Diseases (IMDs) does not incorporate coordinated payment options for clients with severe mental illnesses, thus creating unnecessary complications when utilizing services. Provider incentives would be an effective way to provide care coordination for individuals with MCC.

### **Objective D: Utilize Health Information Technology**

As advocates for community behavioral healthcare, the National Council supports the inclusion of community behavioral health organizations in all of the federal health information technology initiatives. Establishing an interoperable system of electronic health information is critical to encouraging greater care coordination

<sup>8</sup> Depression and Bipolar Support Alliance (DBSA). *Peer Specialist Training*. <[http://www.dbsalliance.org/site/PageServer?pagename=training\\_certified\\_peer\\_specialist](http://www.dbsalliance.org/site/PageServer?pagename=training_certified_peer_specialist)>.

<sup>9</sup> Alakeson, V., Frank, R. G. & Katz, R.E. (2010). *Specialty Care Medical Homes for People with Severe, Persistent Mental Disorders*. Health Affairs. <<http://www.psych.org/Departments/HSF/CHSF/Health-Affairs-Medical-Home-for-SPMI.aspx>>.

among mental health, primary and other health care providers as well as increased engagement of consumers in managing their own care. Both of these goals are key to improving treatment outcomes and overall health.

***Goal 4: Facilitate research to fill knowledge gaps about individuals with MCC***

**Objective B: Understand the epidemiology of MCC**

When determining the distribution of MCC across the population, it is important to recognize the role of Community Behavioral Health Organizations (CBHOs) -similar to rural health clinics and community health centers- in serving this population.

**Objective C: Increase clinical and patient-centered health research**

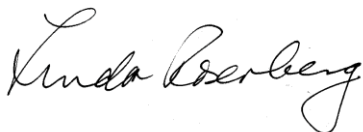
In order to increase clinical and patient-centered health research, it is important to consider CBHOs due to the high prevalence of individuals with mental illnesses and substance use disorders within the MCC population. It is estimated that it takes anywhere between 15-20 years for new interventions to be fully incorporated into usual care in mental health settings.<sup>10</sup> Given this unmet demand for addiction and mental health clinical interventions and the “languish effect” of converting research into practice, it is important to bridge the gap between research and service delivery. Our field desperately needs information on which interventions to use to increase social functioning, reduce symptoms, and support patient recovery.

**Objective D: Address disparities in MCC population**

When building upon the current Department of Health and Human Services’ programs and initiatives that address disparities in the MCC population, it is important to consider community behavioral healthcare. Individuals with severe mental illnesses and substance use disorders often face disparities in efforts to obtain care. For instance, the Latino population in California faces barriers when seeking mental health services due to insurance restrictions and transportation difficulties.<sup>11</sup> As such, initiatives meant to address health disparities should include CBHOs.

The National Council for Community Behavioral Healthcare would like to thank the Department of Health and Human Services for their endeavors to assist individuals with multiple chronic disorders. We hope the commentary we have provided will help to demonstrate the need to consider individuals with mental health and additions and the community providers that serve them. Please let us know if you have any questions.

Sincerely,



Linda Rosenberg, MSW  
President and CEO

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<sup>10</sup> Balas, E. A. & Boren, S. A. (2000). *Managing Clinical Knowledge for Health Care Improvement*. Center for Health Care Quality: University of Missouri. <[http://www.ihl.org/NR/rdonlyres/A375C84E-AE83-422C-B2ED-E11BEE298DE2/0/BalasBorenManagingClinicalKnowledgeforHCImprovement\\_2000.pdf](http://www.ihl.org/NR/rdonlyres/A375C84E-AE83-422C-B2ED-E11BEE298DE2/0/BalasBorenManagingClinicalKnowledgeforHCImprovement_2000.pdf)>.

<sup>11</sup> Rondero Hernandez, V., Capitman, J., & Flores, M. (2008). *Assessing mental health disparities among Latinos in the San Joaquin Valley*. Fresno: Central Valley Health Policy Institute, California State University, Fresno. <[http://www.csufresno.edu/ccchhs/institutes\\_programs/CVHPI/publications/LatinoMH%20Article\\_3%2019%2009.pdf](http://www.csufresno.edu/ccchhs/institutes_programs/CVHPI/publications/LatinoMH%20Article_3%2019%2009.pdf)>.