THE Commission™ | FORMERLY KNOWN AS THE Commission for Case Manager Certification

IssueBrief

June 2024

Integrating Mental and Physical Care: The Role of the Professional Case Manager

Most of us understand the body/mind connection. Unfortunately, our current delivery system does not. For too long, says Benjamin Miller, PsyD, we've approached mental health as something separate from physical health. Such a mindset undermines effective treatment and fails to regard patients in their wholeness.

"What we really need to do is to see it as foundational for all our work. It should just naturally be part of every facet of patient care."

Dr. Miller is a national expert in mental health, policy, and integrating mental health into clinical and community settings. Most recently, he was president of the Well Being Trust. He is currently an adjunct professor in the Department of Psychiatry and Behavioral Sciences at the Stanford School of Medicine, leads the mental health policy fellowship at Inseparable, and consults with a variety of organization and partners on mental health.

Professional case managers, he says, can be powerful change agents, supporting a more integrated approach to accessing mental health care.

It's an essential role, says Teri Treiger, RN, MA, CCM, founder and principal at Ascent Care Management, and a CCMC Commissioner. Patients with chronic medical conditions are much more likely to experience depression than those who don't, she explains. It's a vicious cycle: chronic conditions contribute to depression and anxiety, and depression and anxiety can worsen many

> ***"The cruelest irony in health care is that the more problems you have or the bigger the crisis you're in, the harder you have to work to get help. It shouldn't be that way."***
>
> — Benjamin Miller, PsyD, Past President, Well Being Trust

chronic conditions.[1] Case managers and disability management specialists must recognize this connection to manage complex cases effectively, she says.

There's much to do.

A labyrinth and a lottery

Accessing mental health services can be overwhelming, Miller says. "The cruelest irony in health care is that the more problems you have or the bigger the crisis you're in, the harder you have to work to get help. It shouldn't be that way."

That's the labyrinth. "And then once they finally get into care, whatever that care might be, there's just no guarantee that the quality of the outcomes are going to be there," he says. That's the lottery.

Here are three of the most significant factors contributing to this problem:

1. **Long wait times:** Patients often face months-long waits for appointments, with even longer delays in rural areas, which face severe mental health provider shortages.

2. **High costs:** Mental health care is costly, and many therapists don't take insurance. People pay six times more out of pocket for mental health services than they do any other medical service, he reports. Even if the provider takes insurance, a person's coverage is likely to be inadequate.

3. **Workforce shortages:** Demand is outpacing supply, but the problem isn't just numbers. There is a critical mismatch between the locations of clinicians and the needs of populations.

These challenges contribute to a uniquely American crisis. The U.S. is the only high-income country without guaranteed health coverage, forcing families to spend a substantial amount of their resources on health care, Miller explains. Moreover, he says, the US spends about 18% of its GDP on health care while experiencing a decline in life expectancy.

This decline can, at least in part, be attributed to "deaths of despair," including drug, alcohol, and suicide deaths, exacerbated by economic stresses, social isolation, and the opioid epidemic.

Why we're dying sooner: Deaths of despair

Deaths of despair are also largely a US problem. Many factors converge; he identifies six:

1. **The opioid crisis:** Widespread opioid misuse has dramatically increased overdose deaths. Mismanagement of opioid prescriptions and misguided policies aimed at reducing opioid prescriptions have inadvertently increased the use of more dangerous substances like heroin and fentanyl.

2. **Economic factors:** Financial instability and unemployment significantly increase stress and despair, contributing to substance abuse and suicide.

3. **Limited access to health care:** The cost and complexity of the health care system makes it difficult for patients to receive timely care.

4. **Growing mental health issues:** The growing incidence and prevalence of mental illness, coupled with inadequate access to care means more people are suffering. And many are suffering alone.

1. Herrera PA, Campos-Romero S, et al. Understanding the Relationship between Depression and Chronic Diseases Such as Diabetes and Hypertension: A Grounded Theory Study. Int J Environ Res Public Health. 2021;18(22):12130. Published 2021 Nov 19. doi:10.3390/ijerph182212130

5. **Social isolation:** Isolation and loneliness fuel depression and anxiety, factors in deaths of despair.

6. **Major societal changes:** Political divisions and breakdowns in communities and institutions leave people feeling disconnected and unmoored.

Case managers play a particularly vital role in addressing these challenges and coordinating care, he says. "You are out there making connections. You're out there on the frontlines trying to give people what they need in a timelier manner."

Rethinking assumptions: Five difficult truths

"We have to fundamentally rethink some assumptions we have around health care," he says. That means facing some unpleasant facts:

1. **Whether we like it or not, health care is a business:** The profit motive often fails to align with community well-being, leading to higher costs, poorer access, and worsening disparities.

2. **Health is mostly *not* about health care:** A broad spectrum of factors, including social determinants, lifestyle choices, and community well-being, play a much more significant role than direct medical interventions.

3. **The medical model is insufficient:** The current disease-specific approach is inadequate for addressing the broader health needs of communities. Health can't be managed one disease at a time.

4. **Place matters:** You can't treat people outside the context of community. Where people live plays a huge role in their overall health outcomes. But too often, such data isn't factored into decision-making. It may not even appear in the EHR.

5. **Flawed structures reinforce a reductionist view of health care:** Policy codifies these flaws, leading to repeated investments in systems and approaches that don't work. Mental health is full of legacy programs that remain in place because they've always been in place, he says. "But they don't actually work and they're not able to meet the moment in a way that a new program might."

It doesn't have to be that way. Miller identifies several areas where case managers can help "lead the charge to rethink mental health."

The power of place

Miller poses the following question: If you could receive care anywhere, where would you want that place to be? For some people, it might be the home. For others, it might be at work or school. "We've just assumed that people will always come to us to have their health needs met." It's time, he says, to think about expanding care into more accessible places such as homes, schools, workplaces—and even the community.

He points to the Dutch supermarket chain, Jumbo, which introduced a kletskassa (a chat checkout) for customers seeking social interaction. It's simple, elegant and efficient. The store saw a need and met it—without disrupting their business model. "There's a lot to like here that I feel like health care could learn from," he says.

> ***"We have convinced people that they must see a certain kind of person to get better. This is just not true."***
>
> — Benjamin Miller, PsyD, Past President, Well Being Trust

Another important place is the primary care setting. Miller has long advocated for the integration of mental health services into primary care, a practice proven effective, yet not widely implemented. Despite new payment models and supportive policies, many practices remain hesitant. But primary care represents a significant opportunity to deliver health care in the right place at the right time, meeting patients where they are.

Redefining who provides care

"We have convinced people that they must see a certain kind of person to get better. This is just not true," Miller said.

Miller challenges the conventional wisdom of who should provide care. He advocates for deploying a broader range of community members in mental health roles: training and empowering non-clinicians could significantly expand access to care.

He illustrates this concept with a model adapted from the World Health Organization. It emphasizes low-cost, high-frequency community-initiated care (at the bottom of the pyramid), contrasting with the high-cost, low-frequency specialty care (at the top of the health care pyramid). (See Figure 1 below.)

At the pyramid's base is "community-initiated care." This involves equipping regular people with the skills to support each other's mental health. This model emphasizes the importance of everyday interactions and community support systems, moving away from relying solely on professional intervention.

Task shifting (reallocating tasks to less specialized health workers) could democratize mental health support, making basic care more accessible. Importantly, 80% of effective intervention comes from the therapeutic alliance, the relationship between the patient and caregiver, he says. Case managers, who often have trusted relationships with clients, are well-positioned to enhance care outcomes through these connections.

Platforms: Tech is necessary, but far from sufficient

Technology can play a role in mental health care, but not in the way you may think.

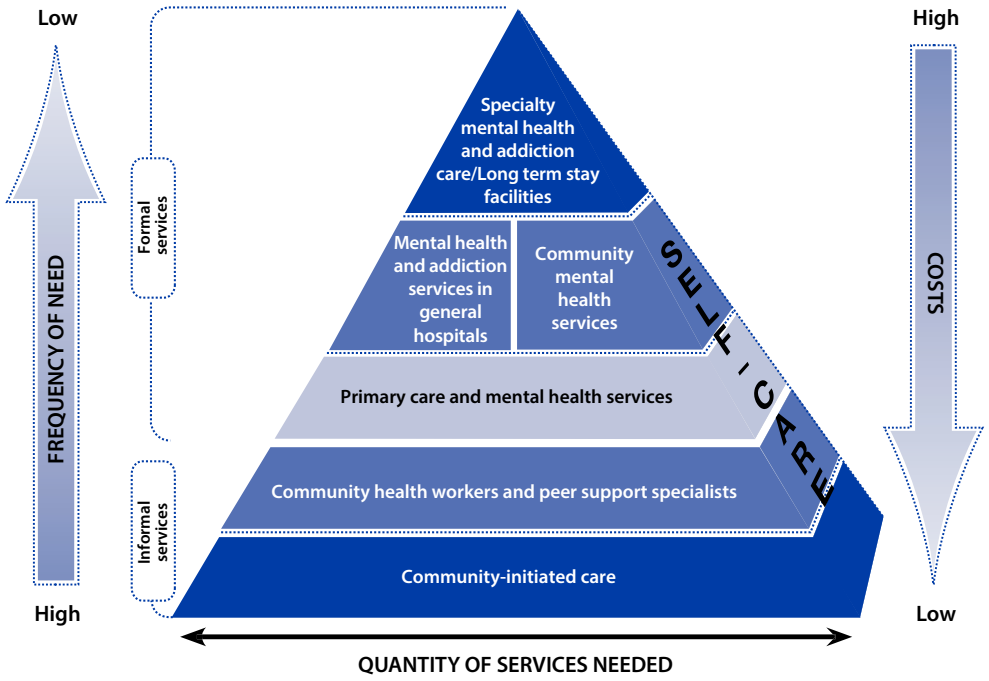

Figure 1. Framework for Mental Health and Addiction Workforce (Revised from WHO) World Health Organization. (2009). Improving health systems and services for mental health (978 92 4 159877 4). WHO Press.

> ***"We need to pay attention to how we leverage that technology and not allow it to replace these fundamental relationships that we have with each other."***
>
> — Benjamin Miller, PsyD, Past President, Well Being Trust

Mental health apps, he says, are not living up to expectations. Technology has become the front door for many people seeking mental health services. It may make sense from an efficiency standpoint, he says. "But I do think that we need to pay attention to how we leverage that technology and not allow it to replace these fundamental relationships that we have with each other," he says. Relationships are the most powerful form of intervention.

Technology enables significant potential to train and empower community health workers. Miller highlights projects like Harvard Medical School's Empower program, which successfully uses online platforms to train individuals to provide mental health services. "It happens all over the world. It just doesn't happen here in the US."

Plan: Let's reconsider who we include in our redesign

Miller calls for more inclusive planning processes and better use of data to design effective mental health interventions. He argues for the involvement of individuals with lived experience in the design and implementation phases of mental health studies and services.

Lancet Psychiatry, for example, now requires researchers submitting studies to show how a person with lived experience was involved in everything from the research question and study design to the writing and dissemination of the findings.

"Think about your own systems or your own work for a second. When was the last time you looked at the data to see where people were coming from? Where are the referrals coming from? Where were people raising their hand saying, 'I need help, I have a problem?' And then where do they go next?"

We can find out if we try, he says. "People leave breadcrumbs along their journey that we don't follow or pick up on."

Prevention: Paying attention to access and SDOH

Prevention, especially in mental health, doesn't get the attention it deserves. Miller stresses is importance in mental health, advocating for upstream interventions before full-blown crises emerge. But systemic barriers prioritize treatment over prevention. "There's always this weird tension in health care that I do think works against our abilities to really go upstream and embrace prevention."

"One of the biggest barriers is that we require a diagnosis before someone becomes eligible for services," he says. "We're never able to fully go upstream and treat the person for whatever the symptoms might be before there's a diagnosis or a problem. That works against us."

Reimbursement props up this broken model: Providers are compensated and rewarded for the complexity of care. The sentiment is "I'm basically doing more because there's more to do," he says. "Well, if we did more prevention, there would be less to do, but we wouldn't be making as much."

Moving upstream means considering economic stability, housing and safety as fundamental aspects of mental health care, suggesting that addressing these issues may be as critical as direct medical interventions.

"If I asked everybody just what's the one thing if we could address, and you addressed it, that could improve mental health or health outcomes, what would it be? I think most people are going to say poverty." The disparities that we see in this country are egregious. And there are certain communities, especially communities that don't

Three ways case managers can assess their success

"How do you feel?"

Some of the key indicators are simple: does a client feel like they are okay, that they're better? "It's very subjective, but yet I feel like we don't ask that question enough."

Instead, he says, we look at other measurable outcomes that don't resonate with the client. "When was the last time a patient cared what their PHQ-9 score was? They don't care about that. They want to feel better. One of the most egregious missteps we've made in mental health is that we've treated mental illness and mental health as if they're the same thing, and they're not. What we've got to do is we've got to instill this notion that mental health is foundational to their health, which means you can measure, does a person feel okay? And then if it gets to the state where it becomes an illness, you can measure that too."

Keep asking

Miller mentions a Pixar movie, *Big Hero 6*. It's about a robot working in health care, and it would shut down only after the patient answered a question. "He would say something like, 'Were you satisfied with your health care experience?" If the answer were yes, he'd shut down. If not, he'd keep asking. "I don't think we ask those questions very often, especially for mental health."

Collect more data around social determinants

Ideally, we want to collect data related to social determinants we can track over time to see if a person's actually getting the social supports they need. "If they don't have a house and we're not making progress with their diabetes, you know why."

have as many resources, they often have some of the worst health outcomes. And it's because poverty is this pernicious determinant of health. For example, finding someone housing can be a powerful mental health intervention.

Case managers: Rise to the challenge

The current crisis has been years in the making, which means it's going to take years to solve, Miller says. "We need more people to be pushing for mental health reform. We need more people to be pushing for ways that we can think differently about who does what, where, and for whom."

He challenges case managers at every stage in their careers: "You are the leaders for this moment."

Treiger offers a similar exhortation. "Case managers have always been on the frontline of health services, but in the aftermath of COVID-19, there's a new frontline. Case managers are being called on to create interventions to connect resources for mental health."

Don't be complacent

One of Miller's mentors once told him, "Once we realize something's not working, it's unethical to proceed as if it is." But that's what's happening in health care. It's time to rethink the role of mental health in our health systems, he says. Everyone needs to be part of that process.

"It's a heavy lift, but if we begin now, maybe the next generation will benefit from it," he says. "They can pick up where we left off and stand on our shoulders just like we stood on other people's shoulders."

Don't be lulled into complacency thinking that this is someone else's job, he warns. "'Oh yeah, we'll wait on the mental health system to sort this out.' No, it's not going to happen. We have to think about what we can do now in the moment to become champions for mental health." ■

About the Experts

Benjamin Miller, PsyD
Past President, Well Being Trust

Teri Treiger, RN, MA, CCM
CCMC Board of Commissioners

Dr. Miller, a clinical psychologist by training, is a national expert in the area of mental health, policy, and ways to integrate mental health into both clinical and community settings.

Miller is a past President of Well Being Trust. Before joining Well Being Trust, Miller spent eight years as an Associate Professor in the Department of Family Medicine at the University of Colorado School of Medicine where he was the founding Director of Eugene S. Farley, Jr. Health Policy Center. He is currently an Adjunct Professor in the Department of Psychiatry and Behavioral Sciences in the Stanford School of Medicine. His doctorate is in clinical psychology from Spalding University in Louisville, Kentucky. He has written and published prolifically on addressing specific health policy and payment barriers for successful mental health integration.

His extensive policy work has led him to be sought out by numerous policy leaders and his experience and professional opinion are renowned and often sought after by presidential candidates, members of congress and state officials regarding how best to advance mental health policy in America.

He's been a longtime supporter of the work of the Commission and has previously been featured in CMLearning Network webinars and a past guest speaker for the Commission's New World Symposium.

Teri Treiger is a thought leader inspiring Conscious Case Management© practice across the health care continuum. She earned her undergraduate degrees in nursing and healthcare administration from Laboure (LAboray) and Stonehill Colleges, respectively. She achieved her Masters of Organization Management at the University of Phoenix. Teri's nursing practice concentrated on acute care, neurosurgery, orthopedic trauma, respiratory intensive care, and emergency/urgent care before shifting to business-focused care coordination and utilization management at managed care organizations and practice management. Subsequently, Teri worked as a clinical product manager developing care management and population health programs at McKesson. Teri oversaw the development and implementation of an uninsured care management program in collaboration with Baptist Health in Montgomery, AL.

Teri is a prolific author in journals and books related to the subject of case management and care coordination. Previously, Teri served as a founding board member of the National Transitions of Care Coalition (NTOCC) and is a past National President of the Case Management Society of America (CMSA).

Teri is founder and principal at Ascent Care Management located in Quincy, MA, where she provides private case management, consulting, professional education, peer mentoring, and publication services.

Commission for Case Manager Certification
1120 Route 73, Suite 200 · Mount Laurel, NJ 08054
(856) 380-6836 · ccmchq@ccmcertification.org
www.ccmcertification.org

Join our community of professional case managers!