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Mental Health Association in Michigan



Mental Health Matters Every Day

Rural Mental Health Neglected By Bill Tennant, Assistant Executive Director

A recent report submitted by the Center of Rural Affairs examines the state of mental health care in rural America. According to the report, Americans remain underserved in terms of mental health care providers and health insurance coverage for mental health services despite the fact that rural Americans suffer as much or more so from mental illness.

Problems of rural and non-metropolitan America are unique and distinct from those of more urban areas. Rural areas, characterized by low population density, limited and fragile economic base, high levels of poverty and limited access to cities, have incidents of serious mental and behavioral health problems (depression, suicide, alcohol and substance abuse) equal to that or greater than urban areas. It is factors such as these which have prevented the timely care and treatment of those suffering from mental illness living in rural America.

Findings from the report include:

- Depression: Major depression rates in some rural areas significantly exceed those in urban areas.
- Teens and older adults in rural areas have significantly higher rates of suicide than their urban counterparts.
- Stress: Stress is associated with increased mental illnesses, and rural people experience stress with cyclical farm crises, natural disasters and social isolation.
- Barriers of availability: There are vast shortages of mental health care professionals in rural areas
- Social Stigma: The stigma attached to mental health problems leads some people to forego treatment.
- Insurance: The lack of insurance is profound as many individuals work for small employers or are self-employed (farmers) and cannot afford extensive health care coverage.

in promoting effective change in mental health care policy in rural America. The suggestions are as follows:

- Prevention: Preventing rather than treating mental illness would prove cost effective and support quality of life for those experiencing mental health issues.
- Telehealth: Barriers to availability of mental health services could be reduced through telehealth technology. Telecommunication systems could make health education and health care available despite distance and logistical barriers.
- Medicaid: As Medicaid covers mental health services, the Medicaid model could be used in addressing mental health care in rural America.
- Mental health parity: Mental health parity under the Mental Health Parity Act of 2008 requires group health plans of businesses with more than 50 employees to cover treatment for mental illness on the same terms and conditions as all other illnesses. The report called on the extension of the Mental Health Parity Act of 2008 to cover many individuals (an additional 113 million people) in rural areas who work for small employers and farmers who are self-employed.

The report concluded that despite rural areas being underserved by mental health professionals, outreach efforts are being made. Still, state and national policy makers operate under a consistent misunderstanding of rural realities and have not created a single policy solution to rural mental health care issues.

A full copy of the Center for Rural Affairs report can be viewed and downloaded at <http://files.cfra.org/pdf/Mental-Health-Overlooked-and-Disregarded-in-Rural-America.pdf>

The report makes several suggestions

Underinsurance a Major Factor in Medical Bankruptcy By Meg LeDuc MHAM Public Policy Intern

In a study published in the August 2009 edition of the "American Journal of Medicine," a team of researchers from Cambridge Hospital, Harvard Medical School, Harvard Law School, and Ohio University, reported that, in 2007, 62.1% of bankruptcies among American families were triggered primarily by overwhelming medical bills, secondarily by loss of income due to illness.

Out-of-pocket health expenses for medically bankrupt families averaged \$17,943 in 2007. And the share of bankruptcies attributable to medical problems rose by 50% between 2001 and 2007. In 1981, only 8% of families filing for bankruptcy did so because of serious medical problems. The researchers defined "medical bankruptcy" by the debtor's stated reason for filing, income loss due to illness, and medical debts over \$5,000 or 10% of pretax family income. The researchers randomly sampled 2,314 filers nationwide and interviewed 1,032 of these filers.

To the surprise of the researchers, three-quarters of these families had health insurance (public or private) at the time of the onset of a major illness. Of these medically-bankrupted families, 60.3% had private insurance. The families were mostly middle-class, college-educated, and homeowners. They are among the growing ranks of the underinsured. Underinsured families have health coverage, but inadequate coverage; when a family member suffers a serious illness, underinsured families find themselves saddled with astronomical out-of-pocket expenses that they are unable to sustain. The number of underinsured Americans, according to a study published in "Health Affairs" in 2008, expanded from 15.6 million in 2003 to 25.2 million in 2007. The researchers estimated that 42% of U.S. adults were underinsured or uninsured in 2007. This was before the deep financial recession that began in 2008.

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The Advocate

A publication for members of the Mental Health Association in Michigan, Joanne Sheldon, Board Chair

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United Way
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Mental Health Association
in Michigan

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Underinsurance hits the middle-class the hardest. The rate of increase of the underinsured was highest among those with incomes above 200% of the poverty line.

Elizabeth Warren, a law professor at Harvard Law School and a co-author of the "American Journal of Medicine" study, estimated in a recent "Washington Post" article that, today, someone files for medical bankruptcy every 30 seconds. This year, medical bankruptcies will total 866,000 and involve 2.3 million Americans. Three-fifths of these Americans will have attended college; two-thirds of them will have owned a home.

Medical bankruptcies obviously have dangerous health consequences for debtors. The Commonwealth Fund estimated that in the past 12 months, 63% of adults with any medical debt problems went without needed medical care because of cost. Only 19% of adults without medical debt problems went without care. Among adults with medical debt, 43% did not fill a needed prescription, compared to 9% without medical debt. The deprivations extended beyond direct medical consequences. Warren estimates that, of families that went medically bankrupt, one-third had their utilities shut off; one-fifth went without food.

The lead author of the "American Journal of Medicine" study, Steffie Woolhandler of Harvard Medical School, was quoted in an interview as saying, "Unless you're a Warren Buffet or Bill Gates, you're one illness away from financial ruin in this country.... If an illness is long enough and expensive enough, private insurance offers very little protection against medical bankruptcy, and that's the major finding of our study."

Woolhandler and fellow author David Himmelstein, another Harvard Medical School professor, are co-founders of the group Physicians for a National Health Program (PNHP). PNHP is a single-issue organization advocating a universal, comprehensive, single-payer national health program. PNHP is reportedly the only national organization of physicians dedicated exclusively to single-payer health care.

Underinsurance and uninsurance are two major issues affecting low-to-moderate-income families. Health insurance often offers adequate protection for those with higher incomes, but affords limited protection to poorer or middle-class families.

Attention, Partners in Crisis (PIC) Coalition Members

Annual PIC Winter Conference
Morning of December 7, 2009
Kellogg Center, East Lansing

Presentations by:

Dr. Sheryl Kubiak, Michigan State University
"Identifying the Mental Health Needs of Jailed Women and
Improving the Continuum of Care Available to Them"

Laura Sager, Campaign for Justice
"The Urgency of Public Defense Reform
for Those Experiencing Mental Illness"

Review of PIC Progress
Discussion of Possible PIC Initiatives for 2010

No charge for PIC members to attend (lunch included)

**For additional information, contact
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**Mental Health Association
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Patient-Centered Medical Home Garnering Attention

By Meg LeDuc – MHAM Public Policy Intern

The concept of what is called a medical home, or a Patient-Centered Medical Home (PCMH), is gaining more and more interest and credence. A PCMH is an approach to providing medical care that seeks to coordinate and integrate all types of care for a consumer and to facilitate strong personal relationships between consumers and primary care physicians. A PCMH would be the point through which all individuals receive their acute, chronic, and preventative medical care services. In a PCMH, a consumer's primary care physician is responsible for directing all care across specialists, hospitals, home health agencies, nursing homes, and all other health care providers. A primary care physician makes referrals to specialists, provides information to other caregivers, evaluates the recommendations of specialists, implements the appropriate ones, and interprets information for families. A PCMH is intended to battle the growing fragmentation of care and requires a centralization of records and thus a substantial investment in information technology. The evidence for establishment of PCMH care is strong: it is generally accepted that a regular source of care and continuous care with the same physician result in more efficient use of care, leading to lower overall health care spending as well as improving morbidity and mortality rates.

The PCMH model was first introduced by pediatricians in the late 1960s as a system of centralizing consumer information. In the late 1970s, the concept of a medical home had been transformed into one recognizing the needs of the total child and family in relationship to health, education, family support, and social environment, especially for the special-needs child. In 1978-1979, Hawaii passed a child health plan that stated, "Every child deserves a medical home." This was an introduction of the PCMH model as it continues today. The Hawaii medical home model was intended to center on family; be community based (geographically and financially accessible); offer continuous, comprehensive, and coordinated care; and use the resources of related services in the community. Medical home care was to be directed by a primary care physician with support from specialists as needed.

A key to the PCMH model is its orientation to "whole person" care, a form of care primary care physicians are best equipped to handle. A physician responsible for whole person care is responsible for care at all stages of life, including acute care, chronic care, preventive services, and end-of-life care. In recent years in the U.S., the trend has been in the other direction; i.e., care directed to specific diseases and organs, rather than concentration on quality of life, the consumer's personal priorities, or potential treatment interactions. A 2003 study published in "The Annals of Internal Medicine" and a 2001 study published in "The Journal of Family Practice" demonstrate that whole person care is neglected. Whole person care is especially lacking in mental health, a deficit that often results in tragic consequences, since mental health conditions, according to the Institute of Medicine, are the leading cause of combined disability and death of women and the second highest of men. (See our last issue for Institute of Medicine investigative recommendations related to mental health and the PCMH concept.) Yet purposeful and highly damaging barriers to mental health care in whole person care have been built, barriers including carve-out payment and referral processes, insufficient time for visits, poor team development, and reinforced stigmas.

Whole person care looks not only at the individual, but at the community as well. The PCMH considers where people live, their exposure to disease, their capacity for changing behaviors, and available public health resources. A PCMH, working at its best capacity, establishes relationships with community agencies that help indigent individuals and with public health departments to share information on patterns of disease and death and to plan interventions. It also develops programs that will educate the community in preventive health measures. Doctors at a PCMH are advocates for socially vulnerable populations.

A PCMH must be supported by an advanced system of sharing information, making information accessible to all providers. The goal of a PCMH is highly developed information-sharing systems that will not only support care providers, but will also help consumers make sense of the advice, tests, diagnoses, and procedures they face along the chain of care. The PCMH model also proposes that physicians accept accountability and voluntarily undergo performance measurement and use these measurements as tools to improve practice. Consumers should have the opportunity to provide feedback to the performance measurement mix.

Use of the PCMH model has the potential for minimizing inequities. Family physicians are the most financially and geographically accessible form of health care and they are far more likely to be located in rural areas or economically disadvantaged urban areas than specialists. The Commonwealth Fund 2006 Health Care Quality Survey found that practices that offer a regular source of care, greater access to physicians, and timely, well-organized care and have the potential to eliminate disparities in access to care for ethnic and racial minorities.

Perhaps the greatest effect of the PCMH model would be on chronic care. Currently, there is a significant lack of continuity in care, particularly for Medicare beneficiaries, many of whom have chronic health problems. A study published in "The New England Journal of Medicine" reported that Medicare beneficiaries have a median of two primary care physicians and five specialists working in four different practices.

The current compensation system would have to be radically reformed to support the PCMH model. Currently, there are financial disincentives to providing adequate primary care; a new system would have to reward continuity, patient-centered care, and accountability. Proposals for such a system range; one suggests a blend of fee-for-service, monthly payments, and bonuses for meeting quality and efficiency performance goals. The Robert Graham Center, which carries out policy studies in family medicine and primary care, suggests that primary care physicians should share in savings from reduced hospitalizations associated with their PCMH practices.

The PCMH model is gaining attention not only from innovative members of the health care community but also from politicians. The reason is cost: the PCMH model, by focusing on primary and preventive care, would cut back on the need for specialty care and thus reduce funds expended. A 2004 study estimated that if PCMH principles were implemented on a national level, "health care costs would likely decrease by 5.6%, resulting in national savings of 67 billion dollars per year, with an improvement in the quality of the health care provided."

On September 19, the "Wall Street Journal" reported that the Obama administration will use Medicare to help fund and direct state pilot PCMH programs. The initiative is modeled on an already-existing Vermont program, which pays doctors an extra \$1.20 to \$2.39 per patient per month to coordinate care. If consumers need to make health changes such as lowering blood pressure or losing weight, the physician engages in referral to a local team of coordinators that help the consumer accomplish the goal but do not charge for that. Under the Vermont plan, which is administered by the Vermont Blueprint for Health, the original physician receives a bonus if the consumer's health improves when measured by certain parameters.

All five health care reform bills in Congress as of mid-October would implement widespread use of the PCMH model. The version developed by the Senate Finance Committee would extend bonus payments to Medicare plans that coordinate care and expand medical homes into Medicaid.

Annual AFSCME Golf Outing

The 15th Annual golf outing of Michigan AFSCME Council 25, to benefit the MHAM was held on August 7, 2009 at the Brookwood Golf Club in Burton, with 73 golfers participating. Over \$33,000 were raised for the MHAM. This brings the fifteen-year event total income generated by our friends at AFSCME to over \$493,000. The MHAM family wishes to thank AFSCME President Albert Garrett, Secretary-Treasurer Lawrence Roehrig and all the AFSCME Council 25 members for their outstanding support of MHAM over the years. This support has been a critical point of assistance to our public policy, advocacy, educational and other work. We also thank the many organizations and individuals who sponsored the event; all of those who did supportive volunteer work; and MHAM Board golf event captains: Kathy Bloch, Joanne Sheldon, Ollie Cameron, Linda Hryhorczuk, Nick Ciaramitaro and Don Boggs.

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Members of AFSCME Council 25 show their support for the MHAM

Left to right: AFSCME Council 25 Staff Representatives Tom Greyerbiehl, Nora Grambau, Barry Thurston and Art Wood

Supporters of MHAM pose for pictures before starting the tournament



Left to right: State Rep. Mark Meadows (D) E. Lansing, Kevin McKinney, Colin Ford and Jon Hansen (Office of State Rep. Kate Segal)