Social Work

and

Integrated

Health Care

From Policy

to Practice

and Back

Edited by Victoria Stanhope and
Shulamith Lala Ashenberg Straussner

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CONTENTS

PART III INTEGRATED HEALTH CARE PRACTICES AND SETTINGS

PREFACE

Victoria Stanhope and Shulamith Lala Ashenberg Straussner

Since 2001, when the Institute of Medicine's report, *Crossing the Quality Chasm*, documented the ways in which the U.S. health care system is failing the American people, health care reform initiatives have been offered at federal, state, and local levels. The high costs of health care, coupled with strikingly poor outcomes in comparison with other high-income countries, have driven a serious reappraisal of how we distribute and structure care—particularly for people with complex health needs. There is widespread consensus about the need to shift the emphasis from acute care to prevention, which addresses the ongoing physical and behavioral health needs of the population. Reform efforts have resulted in the redesign of systems to integrate health care—with the ultimate goal of providing seamless primary care, mental health, and substance abuse services. Although services have traditionally addressed the mind and body separately, there is increasing recognition that they are inseparable with regard to the ways in which people experience health and wellness and how health problems affect their lives.

Recognizing the critical role that the social work profession plays in the health and behavioral health care sectors, we designed this book to help social workers understand the policies and practices that shape integrated health care. The Patient Protection and Affordable Care Act of 2010 promotes reforms to encourage public and private systems to integrate primary care and behavioral health care. Although the future of this legislation is uncertain due to continuing political opposition, the Act was built on reform initiatives that were already taking place throughout the country. The potential for integrated health care to simultaneously improve health outcomes at individual and population levels and significantly reduce costs means that the movement toward an integrated health care system will continue despite the constantly changing health policy landscape. As these changes occur, there is a great need in the social work field for resources that can provide the context for these changes and translate policies into daily social work practice. From policy to practice and back, this book presents the new social work environment emerging

from these important shifts in health care. The focus is on health care for vulnerable populations, with a special emphasis on adults with severe mental illnesses and substance use disorders.

The book is divided into three parts. Part I establishes the need for integrated health care by describing the shortcomings of the current health care system. This section defines integrated health care and elucidates the models of care that have emerged in physical and mental health care to inform the integrated health care approach. Part II focuses on the policies that have shaped health care reform, including background information on public funding for health care, the development of behavioral health services in the community, and the passage of mental health parity legislation. Two chapters describe how the Affordable Care Act and new health care financing models have expanded access and promoted delivery system redesign. Part III presents an overview of integrated health care settings and describes evidence-based practices that are central to integrated health care, such as screening, person-centered care planning, motivational interviewing, and wellness self-management. Various aspects of working in integrated health care settings are detailed, including roles and tasks for social workers, interprofessional practice, and evaluation.

The terminology used to describe integrated health care is evolving as quickly as the health care environment itself. A glossary at the conclusion of this book provides what we understand by these terms at this moment in time. To describe someone who receives services, we have used the terms *individual* and *person* whenever possible. When this usage was ambiguous, we used the term *service user* to avoid the business connotations of *client* or *consumer*, which are terms commonly used in behavioral health. The word *patient* is used only to refer to medical settings or as part of a specific term such as *patient-centered medical home*.

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INTRODUCTION

Darla Spence Coffey

Passage of the Patient Protection and Affordable Care Act (ACA) in 2010 was a watershed moment in the United States and was arguably the most significant piece of legislation passed since the Social Security Act in providing care to U.S. citizens. As vitally important as this law is, it is essential to place it in the context of how our understanding of health and the ways in which health care is delivered in this country have been changing for some time. Changes have been prompted by a number of factors, including advances in science and technology, a more contextualized understanding of the determinants of health, and the rise of the consumerism movement. One of the most important reforms to emerge is the effort to integrate primary care and behavioral health care to promote a holistic perspective of what constitutes health and wellness.

Advances in the understanding of and approaches to health care have also created new and revitalized roles for the social work profession. Although the profession has been engaged in the health sector since its inception, the number of social workers employed and the roles that they have assumed in these settings have varied considerably. Today, social work has an opportunity to lead—and who better to lead in this new era of health care reform than the professionals and scholars who understand that quality care requires responsiveness to social determinants, attention to the risks inherent in transitioning from one form of care to another, and approaches that are culturally appropriate and community based? For social workers to be fully prepared to step into current and emerging roles in health, deliver integrated health care, and provide leadership for national health efforts, we need to focus our attention on the following specific areas.

INTERPROFESSIONAL EDUCATION

The National Center for Interprofessional Practice and Education, or Nexus (https://nexusipe.org/), asserts that improving the experience, outcomes, and costs of health care depends on high-functioning interprofessional teams. The Nexus has also explicitly incorporated the experience of the learner into their work, observing that "interprofessional, collaborative practice occurs when multiple health workers and students from different professional backgrounds provide comprehensive health services by working with patients, their families, carers (caregivers), and communities to deliver the highest quality of care across settings" (Brandt, 2016). Social work programs need to ensure that students are learning in interprofessional settings and are prepared to work in interprofessional teams. There is good evidence that this is already happening; however, we need to ensure that this becomes the rule rather than the exception for modern social work students (Council on Social Work Education [CSWE], 2014).

In 2015, CSWE became an institutional member of the Interprofessional Education Collaborative (IPEC). Its board of directors endorsed the Core Competencies for Interprofessional Collaborative Practice (IPEC, 2016), which include communication, roles and responsibilities, values and ethics, and teamwork, and they are closely aligned with the Educational Policy and Accreditation Standards to which all accredited social work education programs adhere (Commission on Accreditation & Commission on Educational Policy, 2015). Social work programs are encouraged to incorporate the IPEC competencies into their curricula to more thoroughly prepare students to work in interprofessional settings and teams.

SOCIAL WORK RESEARCH

Social work research has contributed to understanding the causes and appropriate interventions for some of the most complex social problems in the country's history (Sherraden, 2013). However, the value of social work research is often eclipsed because of the long-standing preference for pure science. It has become increasingly apparent that for scientific advances to reap their full benefits, we need a greater understanding of how efficacious interventions can be implemented in real-world settings to meet the needs of individuals and communities with full appreciation of their differences. To participate, social work researchers need to be bolder in their research questions and in the application of their findings. Aligning with the trend toward interprofessional delivery of care, social work education programs need to ensure that the next generation of students and scholars is prepared to engage in transdisciplinary research that will best attend to the complex social factors that influence health and health outcomes (Gehlert, Walters, Uehara, & Lawlor, 2015).

POLICY AND ADVOCACY

For social work to assume a leadership role in health, health care, and health care reform, educational programs need to ensure that students are equipped to effectively advocate

for and influence policy at federal, state, local, and organizational levels. More than 16 million Americans gained health care coverage due to the ACA, but the legislation is vulnerable to repeal given the current, highly divided political context. Although parts of the legislation could be improved, we cannot stand idle and allow the country to revert to a time when health care was a privilege for the few rather than a right for all. Beyond the provisions to extend health care coverage to all Americans, the law moves us toward an integrated health care system that is a vast improvement over the costly, siloed, and fragmented system that has existed for decades.

The U.S. Bureau of Labor Statistics (2015) predicts that social work jobs will grow at a faster rate than all other occupations over the next 2 decades. Health care, mental health, and substance abuse social workers will have the largest rate of growth, almost 20%. It is our duty to ensure that social workers are equipped to meet the health challenges of the populace and the evolving practices and policies of the modern health care system.

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SOCIAL WORK AND INTEGRATED HEALTH CARE

INTRODUCTION TO INTEGRATED HEALTH CARE

THE NEED FOR INTEGRATED HEALTH CARE IN THE UNITED STATES

Victoria Stanhope

There is a great divide between what people living in the United States expect from their health care and what is being delivered to them. People wish for health care that is timely, appropriate, effective, and safe. Instead, according to the Institute of Medicine (IOM, 2001), they receive health care that is "overly complex and poorly coordinated" (p. 1), resulting in between $17 billion and $29 billion in costs due to unnecessary care, lost productivity, and disability (IOM, 1999). The growing recognition that the U.S. health care system is in crisis has led to renewed reform efforts from the bottom up in terms of delivery system innovations and from the top down with system changes through legislation.

One of the best ways to understand the extent to which the U.S. health care system has underperformed is to compare it with the health care systems of other high-income democracies, such as Japan, Denmark, and Australia. The United States spends twice as much as most peer countries on health care, with an average spending per capita of $7538 per year (Squires, 2011). However, people who live in the United States have poorer outcomes on key health indicators, including life expectancy, rates of HIV infection and AIDS, drug-related deaths, and disability (IOM, 2013). Compared with 29 other member countries from the Organization for Economic Co-operation and Development (OECD), the United States ranks 22nd in maternal mortality, 23rd in life expectancy for women, and 25th in infant mortality (Schroeder, 2007). This discrepancy between spending and outcomes most clearly demonstrates the inefficiency of the U.S. health care system. The Commonwealth Fund, a private U.S. foundation, rated the U.S. system the lowest of 11 similar industrialized countries, finding that the poorest outcomes were related to access, efficiency, and equity (Davis, Stremikis, Squires, & Schoen, 2014). Weakness in equity signifies that the poor performance of the U.S. system is not uniform but instead rests on profound disparities in access and quality of care. These disparities lead to significant

differences in health outcomes among racial groups. For instance, Asian Americans live 13 years longer than African Americans, and Native Americans live 4 years less than the national average (Lewis & Burd-Sharps, 2014).

What is driving this poor return on investment in health care for Americans? One theory is that the U.S. population has higher health care needs compared with the populations of other countries, but in fact the United States has a relatively young population and an average amount of chronic illness burden (Squires, 2011). More likely, the reasons stem from the way that we organize and deliver care, which differs from that of most peer countries. A key difference is that the United States does not provide universal access to health care through nationalized health care or government-sponsored insurance; as a result, 18.5% of the population was uninsured in 2010 (Holahan & McGrath, 2014). This lack of access occurs partly because most funding for U.S. health care is derived from private sources. In 2008, $3119 of the $7538 per capita health care spending was from private insurance, and the remainder was composed of Medicare, Medicaid, and out-of-pocket spending (Squires, 2011).

Even with this high level of private spending, the United States still spends more public funding on health care than do other similar countries. The diversity of funding streams leads to a highly complex and fragmented system that has to meet the demands of multiple payors. Many siloed systems of care have evolved that treat one aspect of a person's health without coordinating and communicating across systems. Moreover, funding streams determining how care is reimbursed often have more influence on which services people receive than do their actual health care needs. Payors have traditionally incentivized volume over quality, meaning that health care systems have tended to prescribe more care to generate additional funds without considering whether more is actually better (Song & Lee, 2013). Payors are more likely to reimburse acute care (which is often inpatient care) over preventive care, an approach that has driven up costs while not necessarily improving outcomes.

The IOM presented the blueprint for health care reform by setting six aims for high-quality health care (see Figure 1.1). These aims are the fundamental principles that can guide our efforts and the standards by which health care reforms will be judged to have been successful.

To meet these aims, the existing health care system needs major reforms, including insurance reform and expansion to improve access to health care, payment reform to incentivize care that improves outcomes, and system redesign to improve the coordination of health care (Rosenberg, 2013). Social workers are important to all aspects of reform, but our skills and knowledge can play particularly key roles in the coordination of care. This book demonstrates how social workers can solve some of the health care system's most pressing problems. The purpose of this chapter is to explore why the U.S. health care system is failing, to elucidate the particular problems related to integrated health care, and to discuss how these problems relate to social work.

SOCIAL DETERMINANTS OF HEALTH

Although most of us look to health care services to keep us well, health is largely determined by other factors that have traditionally been considered to be outside of the realm

Safe	• Care that is intended to be helpful should not injure service users in any way.
Effective	• Services should be based on scientific knowledge and provided to all who could benefit.
Patient-Centered	• Care should be respectful and attentive to individual service users' preferences and needs and should be guided by service users' values.
Timely	• Wait times and delays should be minimized.
Efficient	• Waste (of equipment, supplies, ideas, and energy) should be avoided.
Equitable	• Quality of care should not vary because of individual characteristics such as gender, ethnicity, location, or socioeconomic status.

FIGURE 1.1: Six characteristics of quality health care. Data from *Crossing the Quality Chasm: A New Health System for the 21st Century,* p. 2, by Institute of Medicine, 2001, Washington, DC: National Academies Press. Copyright 2000 by the National Academy of Sciences.

of health care. In a groundbreaking series of studies conducted in the United Kingdom, Marmot, Rose, Shipley, and Hamilton (1978) examined the health outcomes of 10,308 government workers over a period of 10 years. These cohort studies found that workers in janitorial jobs had three times the mortality rate of those in top administrative positions. This laid the initial foundation for the concept of the *social gradient*, the principle that there is a direct positive correlation between professional rank and mortality rate. Although the findings from comparing those in the highest and lowest employment levels might have been predictable, less predictable was that the relationship held through each level of employment. With each increase in seniority, people experienced improvements in health outcomes and life expectancy.

These studies paved the way for what have become known globally as the *social determinants of health* (SDH). This term refers to any nonmedical factors that impact health. A focus on SDH at the global level and in the United States led to a plethora of studies adding to our knowledge about the ways in which social factors influence health (Kawachi & Kennedy, 2002). Early studies focused mainly on how poverty and deprivation can lead to inequalities in health, whereas many later and more focused studies have investigated how race, gender, education, employment, housing, and citizenship influence health outcomes.

SDH has been conceptualized as including personal behavior, living and working conditions in homes and communities, and economic and social opportunities and resources (Braveman, Egerter, & Williams, 2011). Personal behavior encompasses health-related knowledge, beliefs, attitudes, and conduct, each of which influences a person's health choices and interactions with the health care system. These are *micro* or *downstream* SDH that social workers operating within the health care system and in communities

can address through building relationships, helping people navigate health care systems, and educating and supporting people in their pursuit of healthier behaviors. However, healthier behaviors do not occur in isolation; people are influenced by their social contexts, which include the neighborhoods in which they live, community and social supports, education, and working conditions. These contexts also are shaped by larger *macro* or *upstream* SDH, which are the policies and organizational structures that provide or deny opportunities for people to thrive socially and economically. With this framework, health becomes inextricably connected to more macro policies that reach beyond the scope of health, including issues such as taxation, housing, the environment, and transportation. Understanding health within this person-in-environment perspective, which lies at the heart of SDH, is deeply congruent with the ecological approach of the social work profession (Stanhope, Videka, Thorning, & McKay, 2015).

In comparing SDH with health care itself, it becomes clear why health care reform must move beyond the traditional reach of the health care system. In determining life expectancy, health care plays only a small role (10%), whereas genetic disposition plays a much larger role (30%), and behavioral patterns are the biggest predictor (40%). Therefore, improved health care can make only a small dent in early mortality rates (Schroeder, 2007). The real opportunity to save lives lies in our ability to alter behaviors such as smoking, unhealthy diet, and lack of physical activity. Health care providers can no longer afford to regard people as the passive recipients of treatment (i.e., patients) but must instead recognize the importance of actively involving individuals in their own care and encouraging them to pursue wellness in their homes and communities. However, intervening only at the individual level is insufficient because the causal pathways to health are extremely complicated and influenced by myriad, multilevel factors.

The World Health Organization identified 10 key areas that need to be addressed to promote a healthy population: the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transportation (Wilkinson & Marmot, 2003). All of these domains interact with each other. For instance, early life experiences affect educational life attainment, which can alter employment, earnings, and stress levels. Moreover, the impact of social factors extends far beyond a single person's life. Social disadvantage can span generations by not only affecting people's material circumstances but also altering their biology through epigenetic changes that diminish people's health and capacities (Conley & Rauscher, 2013). Given this broader understanding of SDH, there is great potential for social work interventions. Social workers in all sectors of the profession, including advocacy, community organizing, child welfare, education, health, and behavioral health, can play key roles in contributing to this expanded view of health promotion.

HEALTH CARE DISPARITIES

RACE AND ETHNICITY

One of the greatest challenges for health care reform is to achieve equity in the distribution and quality of care. Health care disparities arise when there are differences between

groups in access and quality of care despite no differences between them in terms of preferences or needs (IOM, 2002). Although Americans experience poorer outcomes overall than people from other similar countries, there are significant variations in outcome across race and ethnicity that persist even after controlling for socioeconomic status, suggesting that the differences are driven by discrimination. This situation evokes grave concern about the adequacy of the health care system to meet the demands of an increasingly diverse society: 13 million residents of the United States were born in another country; one in three identifies as Hispanic or Latino, African American, or Asian; and by 2050, whites are estimated to comprise only 47% of the population (Moore, 2013).

People from minority backgrounds experience differences in how they perceive their health and in health outcomes. Among whites, 59.3% rate their health status as very good, compared with 55.8% of Asians, 44.4% of African Americans, 43.7% of Native Americans, and 33.6% of Hispanics or Latinos (Centers for Disease Control and Prevention, 2008). Perceptions of health reflect actual health outcomes. For example, in 2010, the infant mortality rate was 5.1 deaths per 1000 births among white mothers and 11.6 deaths per 1000 births among African-American mothers (Annie E. Casey Foundation, 2013). Overall, African Americans experience higher rates of heart disease, cancer, homicide, diabetes, and perinatal conditions compared with whites (Kochanek, Arias, & Anderson, 2013).

Despite having a longer life expectancy than other minorities, Asians are still at greater risk for cancer, heart disease, stroke, and diabetes compared with whites, and there are significant differences in health outcomes among Asian subgroups. Ten percent of all Asians and Pacific Islanders have diabetes, compared with 5.9% of the general population, and rates are especially high among American Samoans and Native Hawaiians (Ida, SooHoo, & Chapa, 2012). There are also significant disparities in physical health conditions among Latinos compared with non-Hispanic whites. Latinos are more likely to have liver disease, more likely to be diabetic, more than twice as likely to be diagnosed with HIV infection, and six times more likely to have tuberculosis ("Latino health disparities," 2014).

Mental health outcomes also vary according to race and ethnic group. Overall, the prevalence of lifetime mental disorders among minorities is lower than it is among whites, with the exception of Puerto Ricans, but there are still pronounced differences in terms of specific disorders (McGuire & Miranda, 2008). For example, American Indians and Alaska Natives experience higher rates of posttraumatic stress disorder and alcohol misuse, and are 6.1 times more likely to die of alcohol-related causes compared with the general population (Moore, 2013). African Americans have a higher incidence of schizophrenia than whites; some of this disparity may be attributable to overdiagnosis, but this is unlikely to account for the entire difference. Although Latinos and African Americans may have lower prevalences of mental health disorders than whites, they tend to have more severe and persistent symptoms. One of the most disconcerting findings among the Asian population is that elderly Chinese women are 10 times more likely to commit suicide than elderly white women (American Psychiatric Association, 2014). For adolescent immigrants, the risk of substance misuse increases as they acculturate, with the highest prevalence found among Spanish-speaking immigrants (Gfroerer & Tan, 2003). The picture of disparities in behavioral health is complex and may reflect how culture influences

the ways in which symptoms are understood and reported. Nevertheless, there are specific racial and cultural vulnerabilities that persist even after other SDH are taken into account.

An important factor leading to disparities in health outcomes is treatment barriers. One barrier to receiving equal treatment for many minorities is lack of health care insurance. Even when minorities do have insurance, their plans often place more restrictions on the types of services they cover, and even if they have the same plans as whites, they still are not offered the same services by health care providers. Overall, Hispanics, American Indians, Alaska Natives, and African Americans score worse than whites on a variety of measures related to access and quality of care (Agency for Healthcare Research and Quality, 2011).

Examples of receiving lower quality of care include not receiving the best available treatments, lack of access to preventive care and screening, waiting long periods in clinics and hospitals, less chronic illness care, and poor coordination between primary and behavioral health care systems. One study found that office-based psychiatric visits for African Americans were 4.4 minutes shorter across all visits and 10.5 minutes shorter during first visits compared with whites (Olfson, Cherry, & Lewis-Fernández, 2009). In substance abuse treatment, whites are more likely to be recommended for residential treatment or methadone maintenance compared with Latinos and African Americans (Lundgren & Krull, 2014). Not surprisingly given the higher chances of receiving suboptimal care, the disengagement rates from treatment are higher among minorities than they are among whites (Dixon et al., 2011).

One of the most apparent failures of the health care system is its lack of adequate accommodation for people with limited English proficiency. In one study, 16% of Asian Americans who were not born in the United States said they were not able to understand the information given to them at their primary care clinic, and 46% said they found the doctor's advice hard to follow (Ida et al., 2012). People are often reluctant to ask questions when they do not understand something because of language barriers. Moreover, when there is uncertainty about a course of treatment, language problems and differences in the ways in which a person and a doctor understand the illness can result in a treatment plan that is not centered on the person's needs or preferences (IOM, 2002).

The role of culture runs much deeper than language differences; it extends to the ways in which people seek help, their values and beliefs about wellness, views about self-determination, approaches to decision-making, and personal experiences of illness. For instance, among the Hispanic community, *personalismo* (i.e., being warm and personable) is more important than formality and institutional conventions, and it can determine whether people choose to engage in treatment (Cabassa et al., 2014). On a more structural level, the constant pressure to keep costs down can lead to failure of physicians to offer all available treatments to those whom they perceive as less educated or less likely to request more services, and this disproportionately hurts minorities.

Disparities are driven by overt prejudice and bias, which results in providers' making decisions based on stereotypes rather than treating the individual. The pressure of time can exacerbate these tendencies, with providers not taking the time to understand the complexities of a person's specific experience. An example is the overdiagnosis of African Americans with psychotic disorders rather than mood disorders, which leads to higher

rates of medication, hospitalization, and long-term involvement in the mental health system (Neighbors, Trierweiler, Ford, & Muroff, 2003).

GENDER AND SEXUAL ORIENTATION

Health care disparities are not limited to racial and ethnic minorities; women are also negatively impacted. Overall, U.S. adults die younger than adults in other high-income countries, but this difference is more accentuated for women, indicating underlying disparities (IOM, 2013). Women are vulnerable to a host of gender-specific risk factors that negatively impact their overall health, including higher rates of poverty, exposure to sexual and intimate partner violence, disproportionate burden of caregiving, and general experience of discrimination. Lack of financial resources often results in less access to care and leads women to delay care or not fill prescriptions (Salganicoff, Ranji, Beamesderfer, & Kurani, 2014). These stressors also affect mental health, with women experiencing much higher rates of depression and anxiety than men (Kessler, 2003), and can lead to higher rates of comorbidity. One study found a higher prevalence of mental health disorders among women, notably depression among women with chronic illnesses compared with men with chronic illnesses (Verhaak, Heijmans, Peters, & Rijken, 2005).

Health care disparities also affect lesbian, gay, bisexual, and transgender people, who face many similar challenges, report lower levels of health than cisgender heterosexuals, and are less likely to have insurance coverage or seek health care (Krehely, 2009). Despite differences in sexual orientation and gender, overall medical care has not accounted for these differences in its approach to diagnosis, treatment, or illness management. For instance, although the use of illicit drugs is higher among men than among women, women often encounter poorer treatment than men because interventions have been developed to treat men and do not take into account differences such as specific gender-based traumas, needs related to pregnancy, and child care needs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011).

The increasing recognition of disparities and the mechanisms that lie behind them has made clear the need for the health care system to pay attention to health care at the population level. Each individual should receive personalized care, but to fully understand and prevent illness, the health care system must also address the causes of disorders that function at the group level, which means tracking and analyzing health outcomes of specific groups. Health care reform is tasked with making the health care system more culturally responsive to achieve greater equity in access and quality of care, which will improve health outcomes for all Americans.

COMORBIDITY OF PHYSICAL, MENTAL, AND SUBSTANCE USE DISORDERS

The pressing need for health care reform has focused attention on one particular group of people whose plight illustrates the failure of the U.S. health care system:
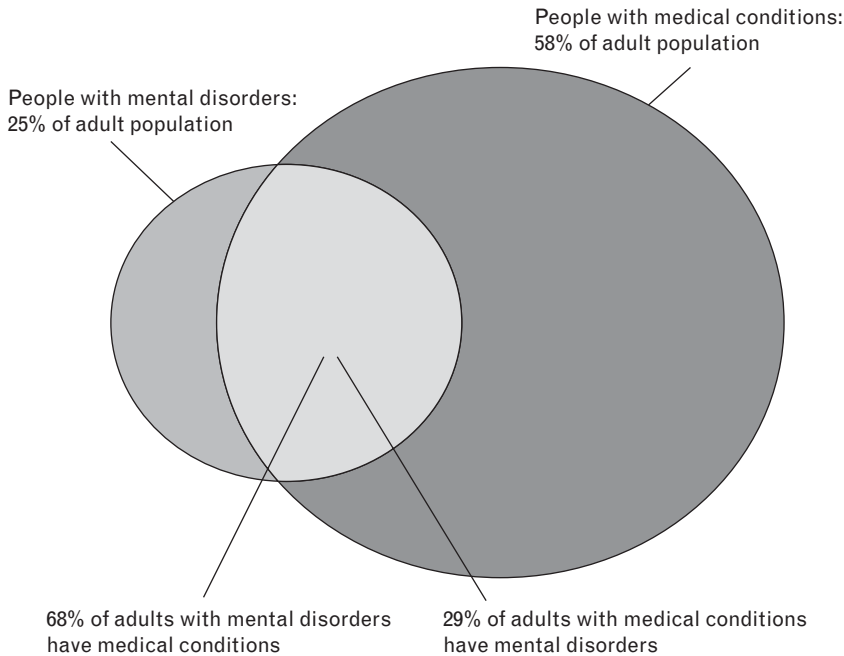
People with medical conditions:
58% of adult population

People with mental disorders:
25% of adult population

68% of adults with mental disorders
have medical conditions

29% of adults with medical conditions
have mental disorders

FIGURE 1.2: Percentages of people with mental disorders and/or medical conditions (2001–2003). Reprinted with permission from *Mental Disorders and Medical Comorbidity* (Research Synthesis Report No. 21), by B. G. Druss and E. Walker, 2011, Princeton, NJ: Robert Wood Johnson Foundation. Copyright 2011 by the Robert Wood Johnson Foundation.

those who suffer from comorbid mental, substance use, and medical health disorders. This group comprises an estimated 17% of the adult population (Druss & Walker, 2011). The 2001–2003 National Comorbidity Survey Replication epidemiological study, the most recent study to have examined the prevalence of behavioral health disorders in the general population, found high rates of physical illness among those with mental disorders. Among people with medical conditions, 29% also had mental disorders; more strikingly, 68% of those with mental disorders also had medical conditions (see Figure 1.2) (Alegria, Jackson, Kessler, & Takeuchi, 2007).

The disproportionate amount of care that this group receives has significant implications for federal and state budgets because most people with comorbid and chronic illnesses receive Medicaid and Medicare. Overall, people with disabilities (many of whom have comorbid illnesses) comprise only 15% of the Medicaid population, but they account for 44% of the Medicaid budget (Kaiser Commission on Medicaid and the Uninsured, 2013). The average cost of treating a chronic illness in a person who also has a mental health disorder is $560 more than the cost to treat the chronic illness alone (Druss & Walker, 2011). Increased understanding of the prevalence and service use patterns of people with comorbid and chronic illnesses has led health care reform initiatives to focus particularly on this population.