



A Holistic Approach Gives the Mind Its Due

BY JOHN MORRISSEY

By now, the key messages of care delivery and payment reform have been drilled into the heads of health care leaders: Treat the whole person. Do it in innovative and efficient ways. Be accountable for maintaining or improving each person's health. And be rewarded or penalized based on how that goes.

Emerging formulas for success involve integrating many different medical settings of care — hospitals, physician practices, post-acute services, community-based care — and also arranging for varied types of clinicians to collaboratively address people's diseases and health habits. Theoretically that will catch and cure problems early, keep complications of chronic illness down and lower the cost of being on the hook for the health of defined populations under performance-based, per-person reimbursement.

But the whole person includes not just the body, but the mind. The implications of behavioral health can be significant to reform aimed at reorganizing the environment of care, experts say. If the largely body-focused strategies for patient-centered care and close coordination of providers do not also seek to incorporate treatment of

mental illness and substance abuse, the ultimate ability to control costs and influence health will be compromised.

"There's been growing recognition that the failure to treat underlying mental illness and substance abuse, when folks have heart disease or diabetes or other chronic health conditions, complicates chronic illness and makes it more expensive," said Charles Ingoglia, senior vice president of public policy and practice improvement with the National Council for Community Behavioral Healthcare in Washington, D.C.

The challenges begin at the primary care practice level. Doctors there are faced with being the sole treatment source for more than a third of all behavioral health disorders,¹ and 80 percent of people with such disorders will visit a primary care practice at least once a year.² These disorders also present time-consuming and difficult situations for emergency departments, and the incidence of these co-occurring disorders among people hospitalized with medical conditions can lead to higher readmission rates. When behavioral patients are referred to appropriate mental health or substance abuse care, they don't make their first appointment 30 to 50 percent of the time.³ Two-thirds of people with a behavioral health disorder don't get treatment at all.⁴

To keep behavioral problems from offsetting the best laid plans of accountable care, providers

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and payers first will have to end the forced separation of physical and mental health that permeates the clinical, operational and financial components of care delivery, said Benjamin Miller, director of the Office of Integrated Healthcare Research and Policy at the University of Colorado-Denver School of Medicine. Care integration objectives now limited to physical health will have to cross over to behavioral health, he said, and, in so doing, “reconnect systems that should never have been disconnected to the level that they are.”

HISTORY OF SEPARATION

Physical and behavioral care delivery systems have grown up alongside each other since the mid-1800s, when states decided to take the mentally ill out of local almshouses and jails and com-

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mit them to state mental health hospitals, said Ingoglia. That lasted into the 1960s, when the federal government invested in building community-based mental health centers — again out of the care mainstream. “Because we’ve been separate from the rest of the health care system, we’re not top-of-mind,” Ingoglia noted.

That divide has been perpetuated by health plans that cover behavioral health off to the side and by health care systems that carve out behavioral care and its reimbursement from their mainstream operations.

“By carving out mental health, what we’re saying is that we want to treat that differently, or separately, from the physical side of the equation,” said Miller. “It does force people to seek care artificially. Instead of just naturally being able to present to primary care and say, ‘I’m depressed,’ the primary care provider may say, ‘Well, you have a benefit for that, and it’s not covering me. Therefore I may send you somewhere else.’”

Referrals to outpatient behavioral health are another sore spot. According to one study, two-thirds of primary care physicians reported not being able to access such services for their patients. Mental health provider shortages, health

plan barriers and lack of or inadequate coverage were all cited as important obstacles to access.⁵

All of that bodes ill for both patients and health care in general. “Statistically speaking, we know that about 1 in 4 adults are going to suffer from a mental health disorder in a given year,” Miller said. That equates to more than 57 million Americans needing remedies and relief, and the vast majority of those identified with such a disorder rely solely on their medical doctor.

“We can easily say that primary care has become the *de facto* mental health system and has been so for decades,” he said.

Absent the integration between physical and behavioral health, prospects of health improvement for the whole person may continue their current dire trend. A number of recent studies have demonstrated that people with serious mental illness die, on average, 25 years earlier than the general population,⁶ and 6 in 10 premature deaths among this population are from underlying chronic diseases — which health care organizations are now destined to be financially at risk to control.

But more common and comparatively less serious mental illness such as depression also can worsen chronic illness. Depression is associated with an increase of 50 percent or higher in the use and cost of health services, as well as with a poorer prognosis and more rapid progression of chronic illnesses.⁷

As accountable care organizations spring up either associated with the Affordable Care Act (ACA) pilots or in concert with private sector partners, “behavioral health integration has to happen in order for these new systems of care to work,” said Michael Lardiere, vice president for health information technology and strategic development with the National Council for Community Behavioral Health. Behavioral health providers have begun introducing medical services to their settings, but “there’s still a need to bring behavioral health into many medical services as well,” he said.

INTEGRATION, BUT LIMITATIONS

Some health care organizations are responding to the need. In Concord, N.H., for example, Capital Region Health Care, a health care holding company with a hospital, physician practice and mental health practice, has placed mental health practitioners in the hospital’s emergency department



PROTECTED INFORMATION COMPLICATES CARE

Substance abuse and addictions are important concerns for the behavioral health care field, and with good reason. Studies report that alcoholism and other substance abuse disorders co-occur in 40 percent to 70 percent of the population suffering from serious mental illness.

Among the general population, about 17 percent have a substance abuse disorder, but that percentage rises to 50 percent or more for people with bipolar disorder or schizophrenia.^{1,2} And 75 percent of homeless people with a drug disorder also have a mental illness.³ The Centers for Medicare and Medicaid Services estimates that 14 percent of uninsured people with incomes up to 133 percent of the poverty level have a substance problem.⁴

That problem reaches into medical care in a big way. According to the Agency for Healthcare Research and Quality, about 15 percent of emergency department visits in 2007 resulted in an admission, but for people exhibiting a substance abuse disorder it was 36 percent. When combined with a diagnosed mental illness, the admission rate was 57 percent.

Integrating substance abuse treatment into medical care can be a touchy issue, however, when it involves disclosing case information on patients outside the inner circle of psychologists and other treatment professionals involved in their care. Federal and state laws protect behavioral health data from unauthorized disclosure generally, and the confidentiality of information about alcohol and substance abuse is especially guarded by a long-standing provision in Title 42 of the Code of Federal Regulations.

These confidentiality laws are complex; they try to cover all kinds of special circumstances — medical emergencies, for example, or criminal investigations. However, the provision known informally in the industry as 42 CFR Part 2 basically restricts disclosure of any information about drug or alcohol abuse — diagnosis, treatment, prognosis, etc. — unless a patient consents in writing. Even so, the

disclosure is generally limited to a particular stated purpose.

Dealing with legal complications represents a significant challenge for health care organizations trying to make their medical and behavioral professionals work well together — how can they supervise a patient's medications, for example, to be sure a prescription for a chronic illness won't interact badly with an addiction treatment?

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Among other ramifications, the mixing of information technology solutions for integrating the continuum of care is stalling — or stopping — at behavioral health. At Capital Region Health Care in Concord, N.H., for example, its hospital, physician group and behavioral health practice all have leading-edge electronic health record systems, but the systems aren't yet linked together because of 42 CFR Part 2, as well as state limitations that are even stricter, said the system's chief information officer, Deane Morrison.

Behavioral professionals camp out in the physician clinics and the emergency department. They represent the interface between information systems, taking medical information and comparing it with what is entered in their separate system, Morrison said. “The greatest amount of drug interactivity occurs between those two classes,” he said. “Figuring out how we’re going to manage those things to minimize the negative interactions is one of the challenges of health care we have to face in our country.”

In Rhode Island, a federally funded pilot is testing whether a statewide health information exchange can overcome

such disclosure problems and become the vehicle for integrating behavioral and physical health information. Called CurrentCare, the health information exchange includes medical records on 200,000 of the state's 1 million residents from primary care offices and hospitals. In 2012, behavioral health providers with electronic records systems started signing up their patients to participate.

Patients must give their consent before CurrentCare adds any of their data, said Lisa DiPrete, a spokesperson for Rhode Island Quality Institute, which operates the health information exchange. Patients can allow any doctor to see their records anytime, any doctor in an emergency only, or only specific doctors.

“It's a very high-touch, lengthy process; it takes longer to enroll people and it costs more, but I'll tell you it pays off in a big way,” said DiPrete. It immediately enables all providers, medical or behavioral, to see the purely medical record of behavioral health patients via the health information exchange network. And a separate consent between a patient and a behavioral facility enables the patient's behavioral data to flow to primary care providers, she said.

— John Morrissey

NOTES

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and at medical group locations, said Deane Morrison, chief information officer.

In Rhode Island, Gateway Healthcare, a large community behavioral health organization, has for the past two decades maintained a presence

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in several of the state's emergency departments, either on call or providing 24-hour coverage, said Richard Leclerc, Gateway's president.

In Oregon, Eugene-based PeaceHealth has a network of primary care clinics with dedicated behavioral health services to help provide triage of distressed patients, crisis management and some direct counseling and psychotherapy, said Rick Kincade, MD, vice president of primary care medical affairs. The Catholic health system also is planning for "reverse integration," or placing primary care staff such as nurse practitioners into behavioral health settings to treat people "that only get care in the behavioral health arena, to the neglect of their medical health," Kincade said.

"It's a group that definitely has higher utilization of emergency services and other services that are fairly expensive," Kincade observed. "We're identifying those patients early and then developing coordinated-care plans between primary care and behavioral health." Triage efforts allow for quick escalation of care intensity such as psychotherapy or medication management, he said. (See story on page 26).

Patients coming into the emergency department with mental health or addiction issues present difficult situations, said Gateway's Leclerc. They may not need immediate treatment or be acutely ill, but they need to be evaluated. Or they are admitted to an inpatient unit "to be discharged five days later and then readmitted a week later because they didn't follow through with the medication or were homeless," he said.

Though there are some positive examples, many grant-funded demonstrations around the country have shown the integration of medical

and behavioral care to be financially unsustainable, even as they deliver promising results, said Miller. That's because the finances themselves contribute to the sustainability challenges. In fact, research published in 2010 showed that the greatest barrier to creating and sustaining such integration was related to separate physical and mental health payment practices.⁸ Just maintaining behavioral and medical duties separately in the same setting is more costly, and financial fragmentation confounds logical integration.

About 6 percent of the nation's population suffers from serious mental illness requiring specialized settings such as community or inpatient mental health facilities,

and those facilities are seeing their reimbursement threatened by state cuts in Medicaid, the predominant source of funding. "Decisions made by the states have a profound effect on the availability of mental health services," said Ingoglia.

From fiscal 2009 through 2012, states have cut mental health spending by more than \$4 billion, according to the National Association of State Mental Health Program Directors. The ACA potentially can improve that situation by supplying funds for states that agree to expand Medicaid eligibility to people with incomes up to 138 percent of the poverty level, but it's up to the states to participate. Lardiere said 25 percent of patients receiving care through behavioral health organizations would gain Medicaid coverage for the first time under that program.

TOTAL COORDINATION EFFORT

While some states are squeezing behavioral health through fiscal policy, others are examining the total cost of care for patients and weighing the prospects of reducing health care costs across the board by merging payment streams and the care they pay for, said Ingoglia. Oregon is a prime example of that mindset. "Instead of limiting the care that people can get, they're going in the opposite direction," he said, "saying that if this is going to work financially, people have to get the right care at the right time."

Legislation enacted in February 2012 created care coordination organizations to which Oregon will direct all Medicaid funds for physical, mental and ultimately dental health, "to then be most efficiently used for that population of patients," said Kincade.



To maintain funding, these care coordination organizations will have to show improvements in quality and cost effectiveness. Targets include a 2-point decline in the state's rate of increase in Medicaid spending over the next two years, from its current 5.4 percent to 3.4 percent.

PeaceHealth has played a major role in establishing a care coordination organization in Lane County, where Eugene is located, an area with a population of 350,000, about 60,000 of whom are Medicaid clients. The health system is the county's largest employer and provides most of the safety-net care. PeaceHealth already operates four of five hospitals in the county and supplies most of the county's outpatient care, so the health system is highly invested in the program's success, said Kincade. That includes a requirement to develop and execute an alternative payment model that involves a coordinated improvement plan not just across the health care sector, but also across school systems, community government, private business and other entities.

Using a network of patient-centered medical home locations with embedded behavioral health providers, PeaceHealth has focused initially on improving screening through standardized instruments for conditions such as depression, anxiety, psychoses and "other psychological determinants of health," Kincade said. Then triage decisions can be made to either treat internally or refer to specialty behavioral care. The initiative also is trying to determine evidence-based practices in medication therapy so the care coordination organization can arrive at "appropriate tiered medication" and consultation.

The approach is intended to use all qualified clinical professionals and make decisions less territorial, without the need for special expertise to handle all behavioral issues. That's a financial as well as integration factor, Kincade said. "We're trying to be stewards of limited resources, to be honest, so we don't have the capacity to care for a bottomless pit of need that exists without working together."

Complex psychoses are a different matter, he pointed out. "The expertise of our limited number of psychiatrists can be saved for those complex patients, and many of the things that can be handled by primary care, should be," he said.

NEW FROM THE GROUND UP

In Colorado, "the similarities are striking" between the Oregon initiative and a pilot getting

underway with funding from the not-for-profit Colorado Health Foundation, said Patrick Gordon, director of government programs for Rocky Mountain Health Plans, headquartered in Grand Junction, Colo. The commercial payer, along with the Collaborative Family Healthcare Association — a membership organization based in Rochester, N.Y. — and the University of Colorado-Denver School of Medicine where Miller is the integration policy director, will test a payment model to sustain behavioral health integration in primary care.

The main objective is to truly merge all factors of success, especially the financial aspects, said Gordon. The health plan is committing to an all-payer support system that advances rather than undercuts the clinical and operational changes that must be made. "The payment system has compounded the bifurcation between physical and mental health," he said, adding that coding systems and fee-for-service incentives have "simply created an economic barrier to this model, which would otherwise make sense." Changing the payment system from the ground up is the starting point of fixing a flawed situation.

Using the Rocky Mountain Health Plans payment system as a laboratory, the pilot partners will recruit up to six practices in western Colorado that already have begun to integrate behavioral health into primary care. As a payer, Rocky Mountain has several contracts covering state,

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county and individual enrollees, and everything within the model is within its discretion as a private entity, Gordon said.

The pilot, which should be underway by spring 2013, has statutory authority to start moving government financing streams together for substance abuse, mental health and physical health care. The federal Centers for Medicare and Medicaid Services and the state Medicaid program are allowing their reimbursements to be combined with commercial sources so that payment to practices is across-the-board, disregarding particular sources and patient enrollments, he said.

The intent is to focus on the operational and clinical change and to figure out on the back end

how to make the economics work. That will benefit not only the practitioners but their patients, he added. Primary care and behavioral health are “part and parcel of the definition of comprehensive care,” Gordon said. “And patients’ experience of comprehensive care should be such that they, themselves, don’t understand that behavioral health services are somehow not part of the whole.”

COMMUNITY ORGANIZATIONS’ ROLES

As health care becomes more attuned to the role of primary care as a point of integration, it will have to be careful not to tune out the needs of seriously mentally ill and addicted people, the core clientele of inpatient and community behavioral health organizations, said Ingoglia. Community behavioral settings “serve as the backbone of the U.S. public mental health and addictions safety

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— Richard Leclerc

net by providing a broad array of clinical and support services that enable individuals with mental illnesses and addiction disorders to live in the least restrictive environment possible and attain personal recovery goals,” he said.

Gateway Healthcare in Rhode Island provides “a large, comprehensive behavioral health care system and social services” that under today’s population-health emphasis can be that point in the care continuum that tracks and shelters patients outside the physical-care sphere, said Leclerc.

Among its holdings are 100 units of subsidized housing under various U.S. Department of Housing and Urban Development grants, and another 75 units through a separate voucher program.

“We see ourselves expanding that, because a lot of times folks can’t be discharged from the hospital because they don’t have any housing,” he said. Other community services include a specialty residential teen substance-abuse program, emergency shelter for families, children’s bereavement center, food kitchen and early childhood and senior center.

Like other such community organizations, Gateway took heed of changes in the air as the

ACA crawled along its path to enactment, deciding “it wasn’t sufficient to be a relatively large provider in the behavioral health care [and] social service field,” said Leclerc. In October 2011, its board began talks with the Lifespan health system and agreed to affiliate in May 2012. Lifespan includes Rhode Island Hospital and Miriam Hospital in Providence; Newport (R.I.) Hospital; Hasbro Children’s Hospital; and Bradley Hospital, the state’s only freestanding children’s psychiatric facility.

One objective is to make handoffs from physical to behavioral care “as smooth as possible and as few as possible,” said Leclerc. Plans include a dedicated behavioral treatment center to which Gateway practitioners stationed at emergency departments can divert appropriately screened patients rather than leave them waiting in distress.

“Someone who’s depressed and crying — they’re in acute pain, but they may be able to be managed and treated outside an emergency department,” he said. Ideally, such patients could stay out of the emergency department completely — their primary care doctors could send them directly to the behavioral health treatment center for evaluation, perhaps an adjustment in medications, and observation. Or a hospital could discharge and monitor the patient at the center for a few days while arranging for a place to send the patient and follow up, Leclerc said.

This alternative to the emergency department is just one possibility for health care organizations seeking to make the most of existing behavioral care services and resources in the community in order to more effectively coordinate the care of these costly patients.

The implications are positive for operating effectively under health care reform. Community behavioral health is set up to use case managers, peer specialists and others besides the more expensive physicians or nurses to monitor and treat people.

“We can probably get better outcomes by having case workers do home visits once a day rather than having someone come in to see a psychiatrist three times a week,” Leclerc said. A bundled payment rate or outcomes-based contracting can provide flexibility to deliver the service “without just looking at who’s billable and what kind of insurance or reimbursement do we get,” he said.

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