Continuum Includes Behavioral Health Care

ROBERT ROOSE, MD, MPH, FASAM

Caring for the whole person is an essential tradition of Catholic health care. Health ministries across the globe share the core value of promoting and protecting human dignity, inclusive of biological, psychological, social and spiritual self.

At Mercy Medical Center and Providence Behavioral Health Hospital in western Massachusetts, the legacy of the founding Sisters of Providence is a deep understanding of behavioral and social conditions' impact on health. The sisters recognized the importance of designing systems to deliver integrated, patient-centered, holistic care.

Time and again, over more than 140 years as a transforming, healing presence in the community, the Sisters of Providence have demonstrated that the road to better health is paved with better behavioral health. What (and how much) we eat, where we live, how often we walk, if we smoke, drink or use other substances, all are choices we make that directly influence our bodies, our minds, our health and our community. It follows that when the ability to engage in positive health-oriented behaviors is impaired or impeded, our collective health suffers — and when we can educate, intervene and integrate behavioral health care into whole person care, individual and public health improves.

I am hopeful that, as a country, we have arrived at the same conclusion. As we increasingly move into a value-based health care landscape, where meeting the Triple Aim is hand in hand with fulfilling the mission of providing whole person care, the urgent need to promote and integrate behavioral health care has never been greater.

BEHAVIORAL AND PHYSICAL HEALTH

Behavioral health conditions, including mental health and substance use disorders, are extremely common in the United States, affecting 1 in 4 Americans and resulting in health care costs of more than $250 billion each year.[1] (Tobacco use remains the leading cause of preventable death and illness, contributing to more than 480,000 deaths each year, followed by high blood pressure and obesity.)

The country faces a devastating opioid epidemic that has resulted in drug overdose surpassing motor vehicle accidents as the leading cause of accidental death.[2]

Mental health conditions such as depression and anxiety disorders also tend to be common among both young adults and elders and lead to significant disability and poor health outcomes. The vast majority of individuals with behavioral health conditions also have co-occurring chronic physical illness. Evidence suggests that having a mental health disorder results in lower use of medical care, reduced adherence to treatment for chronic diseases and increased risks for worse outcomes. Physical conditions often exacerbate behavioral health conditions, and behavioral health conditions can prevent or complicate treatment for a physical illness. Substance use disorders, in particular, often result in additional medical consequences or significant morbidity

from physical illnesses such as cancer, heart disease, liver disease, HIV and hepatitis C.

Individuals with behavioral health disorders are more likely to live in poverty, have unstable housing, a lower socioeconomic status and lower educational attainment — all factors that can negatively impact health outcomes. Yet in spite of this, behavioral health care remains largely fragmented from the rest of the health care system, challenging the notion of providing whole person care and threatening the opportunity to achieve better health.

The vast majority of patients with behavioral health conditions initially come to emergency departments and primary care clinics, where providers often lack the time, training and resources to recognize and treat the condition. Access to specialized behavioral health treatment typically occurs in outpatient community-based or hospital settings that are not well connected to other physical health services. Most often, the patient receives outpatient treatment with medications only, and no cognitive or behavioral therapy. Compounding the limited access and fragmentation in care for behavior health patients are nationwide, severe shortages of trained behavioral health providers such as psychiatrists, addiction specialists, psychologists and social workers. Even if a patient is able to get a referral for care, many do not follow up.

It is quite troubling, but overall, most adults with behavioral health conditions ultimately receive no treatment at all. This is no way to design or operate a system aiming to provide whole person care when people need it, how they need it and where they need it. And such systemic failure to appropriately integrate behavioral health screening, intervention, and treatment impairs our collective ability to achieve the Triple Aim. Patients with behavioral health diagnoses ultimately use more medical resources, are more likely to be hospitalized and are readmitted to the hospital more frequently.[3]

OVERCOMING BARRIERS

The evidence for bringing together behavioral health and physical health is strong, yet true integration is rare. One of the most significant barriers has been a lack of financial incentives. Payers often use separate networks, billing and coding practices; reimbursement rates for behavioral health services traditionally are very low; and there can be complex or onerous prior approval stipulations on certain types of medications or services when delivered in primary care or other medical settings.

Integration also holds operational implications. Primary care or other physical health providers and behavioral health providers will have to adapt to new forms of collaboration. This may involve understanding new confidentiality protections; developing new ways to share health records; and establishing different communication patterns and entirely new workflows built on shared goals.

In a broad set of disciplines, medical training provides little formal education or training on behavioral health diagnosis or treatment, and stigma about such conditions has pervaded health care settings. Until driven by efforts to address the opioid epidemic, education on treatment of substance use disorders was virtually nonexistent. In order to have effective integration and whole person care, all members of integrated multidisciplinary teams must gain additional diagnostic and treatment skills, as well as knowledge, to ensure that provider attitudes are aligned with our core value of human dignity.

To overcome some of these barriers, health care systems that have developed behavioral health services and integrated care into physical health settings often have done so through funding the initiatives themselves, acquiring supplemental state funds or relying on donations or grants. Other organizations have used Medicare and Medicaid demonstration programs and waivers that enable them to accept bundled or global payments for delivering care. Still other systems — including Mercy Medical Center and Providence Behavioral Health Hospital — have used a combination of all of the above, with the goal of developing an Accountable Care Organization and sharing in savings through improving health outcomes and reducing costs.

VALUE-BASED CARE AND ACO DEVELOPMENT

In 2016, the Commonwealth of Massachusetts received federal approval of a five-year Medicaid (MassHealth) 1115 waiver in order to restructure the program and move from its current fee-based model to a system of ACOs. The stated goal of the waiver is fivefold:

1. Implement MassHealth ACO models as provider-led organizations that are accountable for

the cost and quality of care

2. Improve integration among physical health, behavioral health, long-term services and supports and social services

3. Maintain near-universal health insurance coverage

4. Address opioid epidemic through expansion of recovery-oriented services

5. Provide sustainable support to safety-net hospitals to ensure access to care for low-income individuals

With the approval of the waiver, effective in July 2017, a total of $1.8 billion of funding over five years will be distributed to support infrastructure investments to develop the integrated, coordinated models of care for an ACO, the infrastructure of community partners for behavioral health and long-term services and supports, and innovative ways of addressing social determinants of health.

In partnership with the Boston Medical Center HealthNet Plan, Mercy Medical Center was awarded the opportunity to partner with MassHealth to develop an ACO. Building on existing work and leveraging an extensive behavioral health continuum of inpatient and outpatient care, the ACO will expand behavioral health integration in both the acute and outpatient settings, incorporate new strategies to intervene on social determinants and develop a workforce of community health workers and behavioral health specialists. Informed by the Sisters of Providence legacy and existing models, the infrastructure funds will support education and training, common care coordination platforms and innovations in the delivery of care. Incentives are aligning to improve the delivery of care for this complex population — and so it appears that the future for integration and whole person care is upon us.

THE FUTURE IS NOW: INTEGRATION AND INNOVATION

Certain health care reform efforts, like the MassHealth ACO model, are giving new impetus and support to designing systems of whole person care for individuals with behavioral health conditions. Provider accountability for outcomes and costs will ignite improvements in the coordination and provision of behavioral health care across settings. Expansion remains critical, as does preservation of health insurance coverage, along with parity laws that prevent insurers from placing greater financial requirements or treatment restrictions on mental health or substance use disorder treatment than on other, comparable medical care. And so although barriers still exist, new opportunities to invest in establishing essential service to our community give great cause for optimism.

I am quite sure the development and operation of our ACO will be an interesting and rewarding journey. In some ways, it is uncharted waters — yet the potential for behavioral health to show its true value is undeniable. Even in these times of great change, I believe our collective systems have the power to transform the delivery of care in this deeply important way. After all, another one of the many traditions of Catholic health care is its pioneering spirit. So, with behavioral health integration and delivery of whole person care, let us, in the words of Mother Mary of Providence: "Never rest on what has been done, but rather press forward to what remains to be accomplished."

It is the right thing to do.

ROBERT ROOSE is vice president, behavioral health, Mercy Medical Center and affiliates in Springfield and throughout western Massachusetts.

NOTES

1. Center for Behavioral Health Statistics and Quality, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (Rockville, Md.: HHS Publication, 2015) www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.

2. Rose Rudd et al, "Increases in Drug and Opioid Overdose Deaths — United States, 2000-2014," *Morbidity and Mortality Weekly Report* 64, no. 50 (Jan. 1, 2016) 1378-82. www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm.

3. Benjamin G. Druss and Elizabeth R. Walker, "Mental Disorders and Medical Comorbidity," *Research Synthesis Report No. 21* (Robert Wood Johnson Foundation, February 2011). www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1 (accessed July 25, 2017).

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September - October 2017
Copyright © 2017 by The Catholic Health Association of the United States