Advancing mental health in Virginia: Considerations for policy

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CREATING A CULTURE OF WHOLE HEALTH

Recommendations for Integrating Behavioral Health and Primary Care

Multi-Method Findings Aligning the Literature, Interviews, Focus Groups, and a National Leader Summit

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The next step

• To inform policy and catalyze action that establishes integrated care for whole health

• Piloting efforts to better connect healthcare stakeholders – especially payers, states and policy makers, and funders – to advance integrated care for whole health

• The 15-month grant will specifically support a planning year and three months of piloting
The pieces for integration

• Access
• Attribution
• Accountability
• Alignment
• Analytics
• Ask
Improving access for mental health services requires us to have a no wrong door policy for entry.

**ACCESS**
Tell the Virginia story on mental health

### FY 2014 Community Funding by Source for Behavioral Health Services

<table>
<thead>
<tr>
<th>Sources</th>
<th>Funds</th>
<th>Sources</th>
<th>Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Funds</td>
<td>$241,266,474</td>
<td>Federal Funds</td>
<td>$53,573,889</td>
</tr>
<tr>
<td>Local Funds</td>
<td>$161,806,241</td>
<td>Other Funds</td>
<td>$23,415,355</td>
</tr>
<tr>
<td>Fees (incl. Medicaid)</td>
<td>$251,598,029</td>
<td>Total Funds</td>
<td>$731,659,988</td>
</tr>
</tbody>
</table>

### Average Wait Times in Weeks for CSB Ambulatory Services in 2013

<table>
<thead>
<tr>
<th>Services</th>
<th>Mental Health</th>
<th>Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults</td>
<td>Children</td>
</tr>
<tr>
<td>Medication Services</td>
<td>6.00</td>
<td>5.75</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>5.90</td>
<td>6.07</td>
</tr>
<tr>
<td>Counseling/Psychotherapy</td>
<td>6.38</td>
<td>4.28</td>
</tr>
<tr>
<td>ACT/Intensive In-Home*</td>
<td>11.24</td>
<td>3.33</td>
</tr>
<tr>
<td>Medication Assisted Treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
More programs are not the solution
In 2013, mental health was estimated to be the most costly condition.

- Pulmonary Conditions
- Cancer
- Trauma
- Heart Conditions
- Mental Health: $201 Billion

RISE IN SUICIDE IN AMERICA

“U.S. Suicide Rate Surges to a 30-Year High”

Rise in suicide rate for middle-aged men and women (45-64)

Findings from National Center for Health Statistics found increase in suicide in every age group except for older adults

Overall suicide rate rose

1999

2014

43%

63%

24%
Many individuals who die by suicide have recently had a primary care visit

45% 20% 73%
1 Month 24 Hours Elderly – 1 Month

Luoma, Martin, & Person, 2002; Pirkis & Burgess, 1998; Juurlink et al., 2004
Visits for Individuals with Poor Mental Health

49% Primary Care Only
18% No Visit
14% Primary Care + Mental Health
14% Other Combo
5% Mental Health Only

Findings from 109,593 respondents to the 2002-2009 Medical Expenditure Panel Surveys (MEPS)

### Fragmentation is Costly

<table>
<thead>
<tr>
<th>Condition</th>
<th>Annual Cost – those without MH condition</th>
<th>Annual Cost – those with MH condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Condition</td>
<td>$4,697</td>
<td>$6,919</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>$3,481</td>
<td>$5,492</td>
</tr>
<tr>
<td>Asthma</td>
<td>$2,908</td>
<td>$4,028</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$4,172</td>
<td>$5,559</td>
</tr>
</tbody>
</table>

Head-to-Head Comparison

• Five year, federally funded study
• 321 children
  – 160 received treatment at PCP’s office
  – 161 received treatment at mental health provider
• Outcome:
  – PCP: 99.4% initiated care and 76.6% completed
  – MH: 54.2% initiated care and 11.6% complete

As shown above, an estimated $26 - $48 billion can potentially be saved annually through effective integration of medical and behavioral services. To put these nationally projected savings in context, the total national expenditures for mental health and substance abuse services provided by all physicians, including psychiatrists and non-psychiatric physicians, is projected to be about $35 billion by 2014. This estimate is before recent changes resulting from the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (PPACA), which will likely increase this spending estimate.
Inmates meeting criteria for mental health problem within previous year

- State Prison: 56.2%
- Federal Prison: 44.8%
- Local Prison: 64.2%

Approximately
- State
- Federal
- Local

Received mental health treatment since admission

A unique opportunity for Virginia

Most states, while aggressively pursuing strategies to address mental health and substance use, are doing so on the back of new programs, payment models, and policy decisions.

Rarely do states have the opportunity to make transformative systems changes that bring mental health and substance use seamlessly into the fabric of care delivery.
Guiding Principles

• Standards for mental health and substance use provision
• Oversight of delivery and financing
• Transparency of process
• Accountability to goals, including cost, outcomes, and other quality measures like access
Fragmented financing, delivery systems, and services exacerbate poor health outcomes for children, adolescents, adults, and older adults

• Access to mental health and substance use services do not meet the needs of the community
• Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations
• Social determinants of health, including insufficient housing, employment, and transportation, create barriers to mental health and substance use resources that vary by community
Who holds the risk for people with mental health needs?

ATTRIBUTION
Attribution examples

- Attribution for patients can be done one of two ways:
  - a) plurality of visit (three visits within a calendar year); or,
  - b) auto enrollment by entity at a predetermined point in time (e.g. annual enrollment).
- The goal is to provide a consistent point of contact and accountability for the Commonwealth.
- This approach will help mitigate any selection bias and denial of responsibility on the part of clinics and providers for mental health.
- The specifics of this mechanism are basic:
  - once a site has the person attributed to them, they are responsible for their care, and bear the financial risk when they do not meet certain standards or quality measures.
  - The financial risk for these people must be aligned to ensure adequate incentives for success as well as financial penalties for not adequately addressing mental health.
How can hold each setting accountable for taking care of mental health?

ACCOUNTABILITY
Accountability across the system

• Responsibility for health and mental health must be shared across settings, including the mental/behavioral health system, hospitals and emergency departments, primary care, schools, housing, public safety, first responders, and the judicial system.

• Sites are accountable for a) identifying; b) treating; c) referring; and, d) following up.

• Establish standards for referral pathways, warm hand-offs, transitions, and team based care.

• Include role definition and scope for clinicians.
How can we ensure that state agencies are aligned, working together to integrate?

ALIGNMENT
WHAT DO YOU WANT YOUR MENTAL HEALTH SYSTEM TO BECOME?

Alignment requires shared vision
Data are foundational

ANALYTICS
DMAS and Data

• Inpatient Facility (Behavioral)
• Inpatient Facility (Medical)
• Outpatient Facility (Behavioral)
• Outpatient Facility (Medical)
• Outpatient Professional (Behavioral)
• Outpatient Professional (Medical)
• Prescription drugs (Behavioral)
• Prescription drugs (Medical)
What we need to do moving forward

ASK
THOSE WHO SAY IT CAN’T BE DONE ARE USUALLY INTERRUPTED BY OTHERS DOING IT

James Baldwin
CONCEPTUAL FRAMEWORK
1. Create standards of care and competencies for delivery across multiple settings

• Create consistency of what people can expect for mental health in multiple settings (e.g. schools, prisons, primary care), and implement site specific standards workflows based upon level of the person’s behavioral health need
2. Workforce

• Perform a needs based assessment for current behavioral health workforce to identify gaps
• Assess who is best suited for certain services in specific settings
3. Data, information exchange, and coordination of care

• Create a minimum data set for mental health to be used by all facilities, clinics and clinicians across Virginia that prioritizes patient level outcomes.

• The creation of this data set begins with a) identifying all existing and required measures and metrics and assessing which ones will drive the greatest system improvements, b) parsing measures down based upon stakeholder refinement (e.g. payers), c) establishing an evidence framework for measurement, and, d) creating an auditing process that can be used to benchmark and hold stakeholders accountable using state data systems.
4. Payment reform matters

• This is not about changing the way we pay for mental health; this is about changing the way pay for health care that includes mental health
• Make sure each delivery setting is getting paid by keeping the patient healthy, not per patient visit (e.g. move as quickly as possible away from FFS)
• Put financial incentives in place to encourage health care clinicians to work with mental health
5. Decisions, decisions, decisions

Mental health policy

• Protect the safety net
• Focused on special populations (e.g. SPMI)
• Mental health often financially carved out for this population

Health policy

• Support primary care
• Focused on general population
• Mental health often left out of payment models

All health policies should be measured against the question, “Will this limit my patients’ choice in receiving mental health where they want?”

Integration requires us to rethink our policy
WHO is covered?

WHAT is covered?

What is the level of payment?

What is the form of payment?
Questions?

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