Advancing mental health in Virginia: Considerations for policy

Benjamin F. Miller, PsyD
Eugene S. Farley, Jr. Health Policy Center
University of Colorado School of Medicine

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

Benjamin F. Miller, PsyD
Emma C. Gilchrist, MPH
Kaile M. Ross, MA
Shale L. Wong, MD, MSPH
Larry A. Green, MD

Eugene S. Farley, Jr. Health Policy Center
University of Colorado School of Medicine

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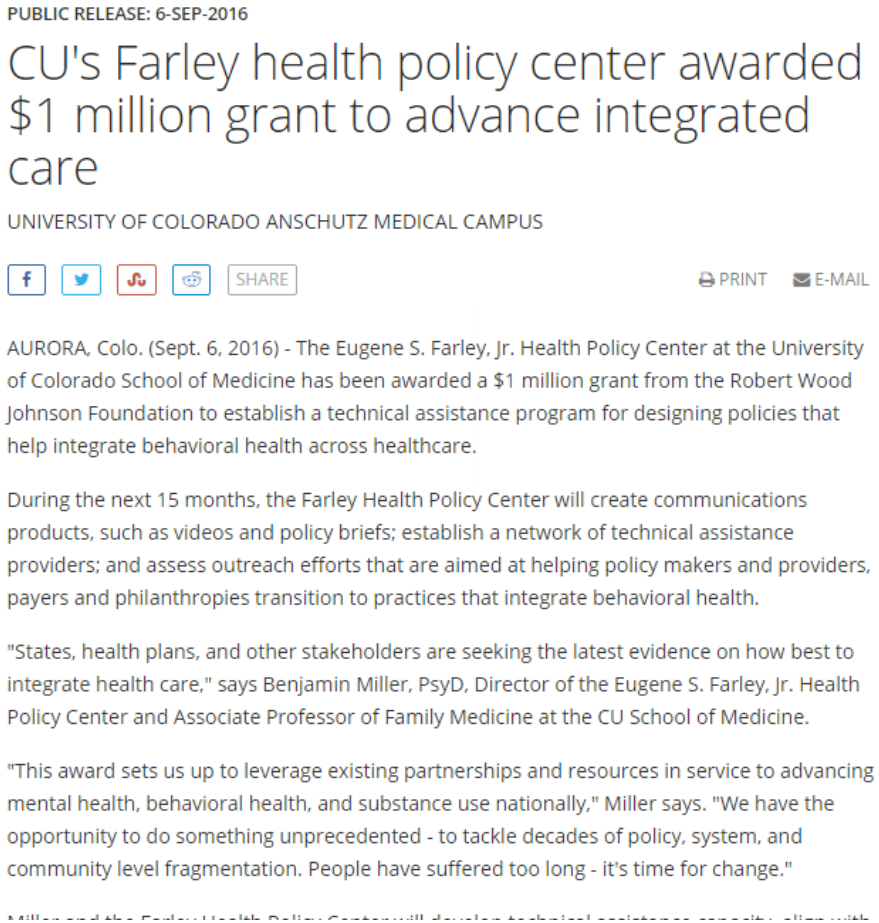
EUGENE S. FARLEY, JR.
HEALTH POLICY CENTER

The next step



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CU's Farley health policy center awarded $1 million grant to advance integrated care

UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

SHARE PRINT E-MAIL

AURORA, Colo. (Sept. 6, 2016) - The Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine has been awarded a $1 million grant from the Robert Wood Johnson Foundation to establish a technical assistance program for designing policies that help integrate behavioral health across healthcare.

During the next 15 months, the Farley Health Policy Center will create communications products, such as videos and policy briefs; establish a network of technical assistance providers; and assess outreach efforts that are aimed at helping policy makers and providers, payers and philanthropies transition to practices that integrate behavioral health.

"States, health plans, and other stakeholders are seeking the latest evidence on how best to integrate health care," says Benjamin Miller, PsyD, Director of the Eugene S. Farley, Jr. Health Policy Center and Associate Professor of Family Medicine at the CU School of Medicine.

"This award sets us up to leverage existing partnerships and resources in service to advancing mental health, behavioral health, and substance use nationally," Miller says. "We have the opportunity to do something unprecedented - to tackle decades of policy, system, and community level fragmentation. People have suffered too long - it's time for change."

- *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

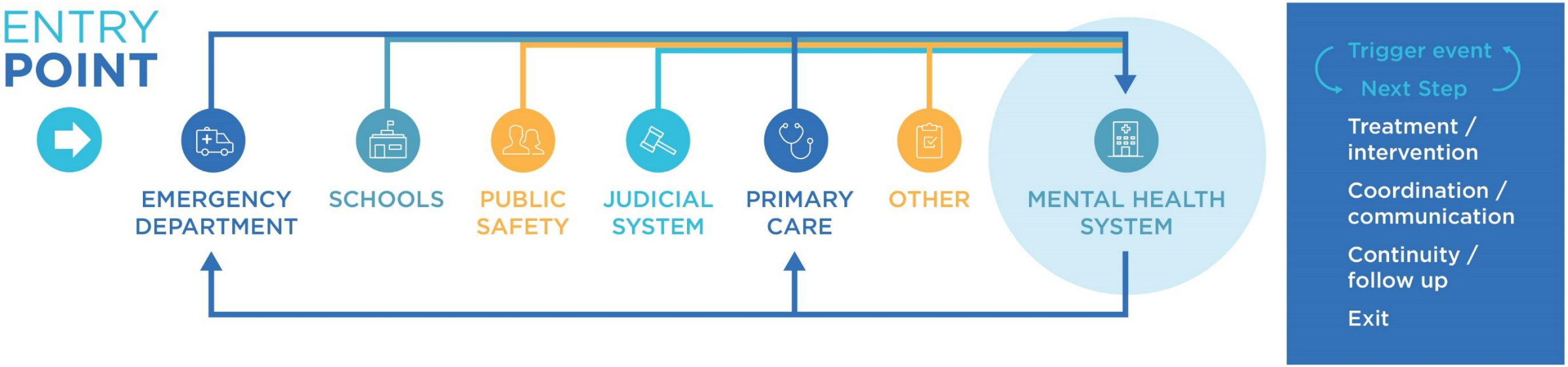
ACCESS

Tell the Virginia story on mental health

FY 2014 Community Funding by Source for Behavioral Health Services			
Sources	Funds	Sources	Funds
State Funds	$241,266,474	Federal Funds	$53,573,889
Local Funds	$161,806,241	Other Funds	$23,415,355
Fees (incl. Medicaid)	$251,598,029	Total Funds	$731,659,988

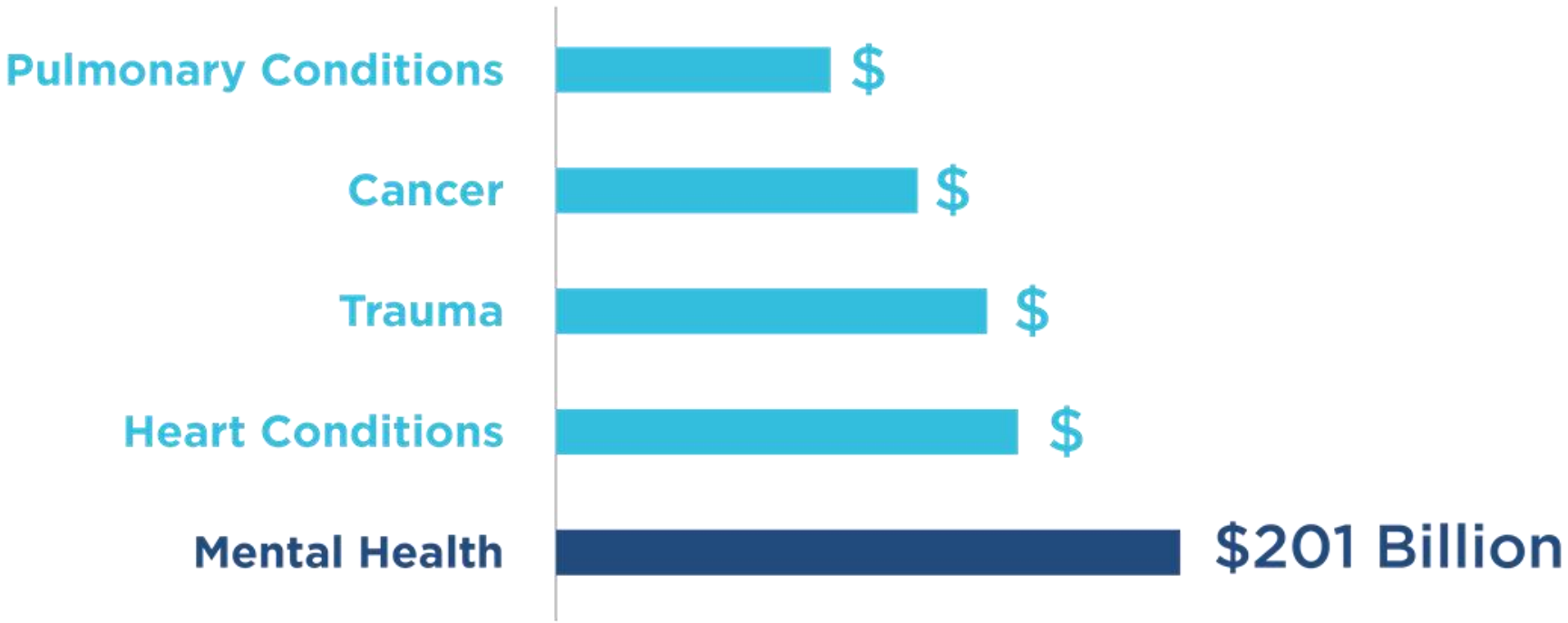
Average Wait Times in Weeks for CSB Ambulatory Services in 2013				
Services	Mental Health		Substance Use Disorder	
	Adults	Children	Adults	Adolescents
Medication Services	6.00	5.75	6.48	5.74
Psychiatric Services	5.90	6.07	6.12	5.95
Counseling/Psychotherapy	6.38	4.28	4.48	3.83
ACT/Intensive In-Home*	11.24	3.33		
Medication Assisted Treatment			9.25	1.00

More programs are not the solution



THE COST OF MENTAL HEALTH

In 2013, mental health was estimated to be the most costly condition

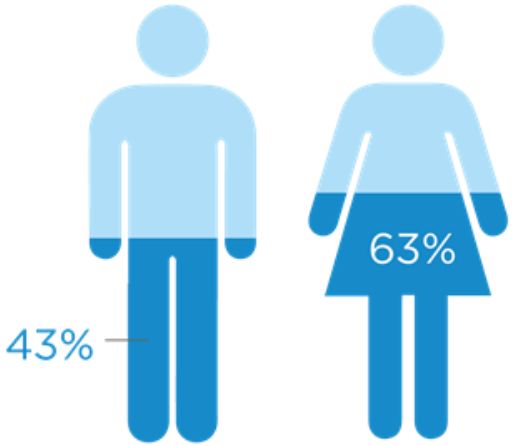


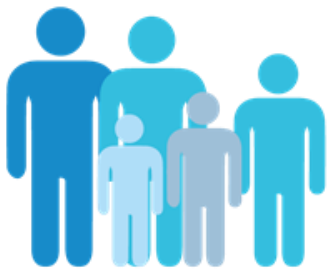
Roehrig, C. (2016). Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. *Health Affairs.*

RISE IN SUICIDE IN AMERICA

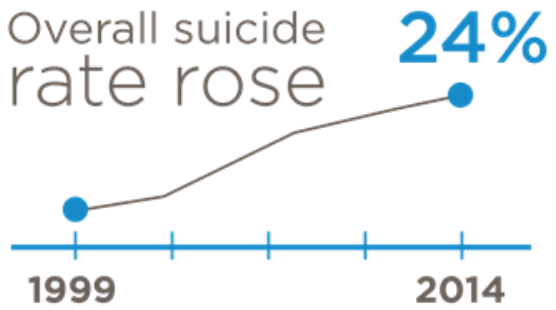
New York Times (April 22, 2016)

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**



SUICIDE DEATHS & PRIMARY CARE VISITS

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

45%
1 Month

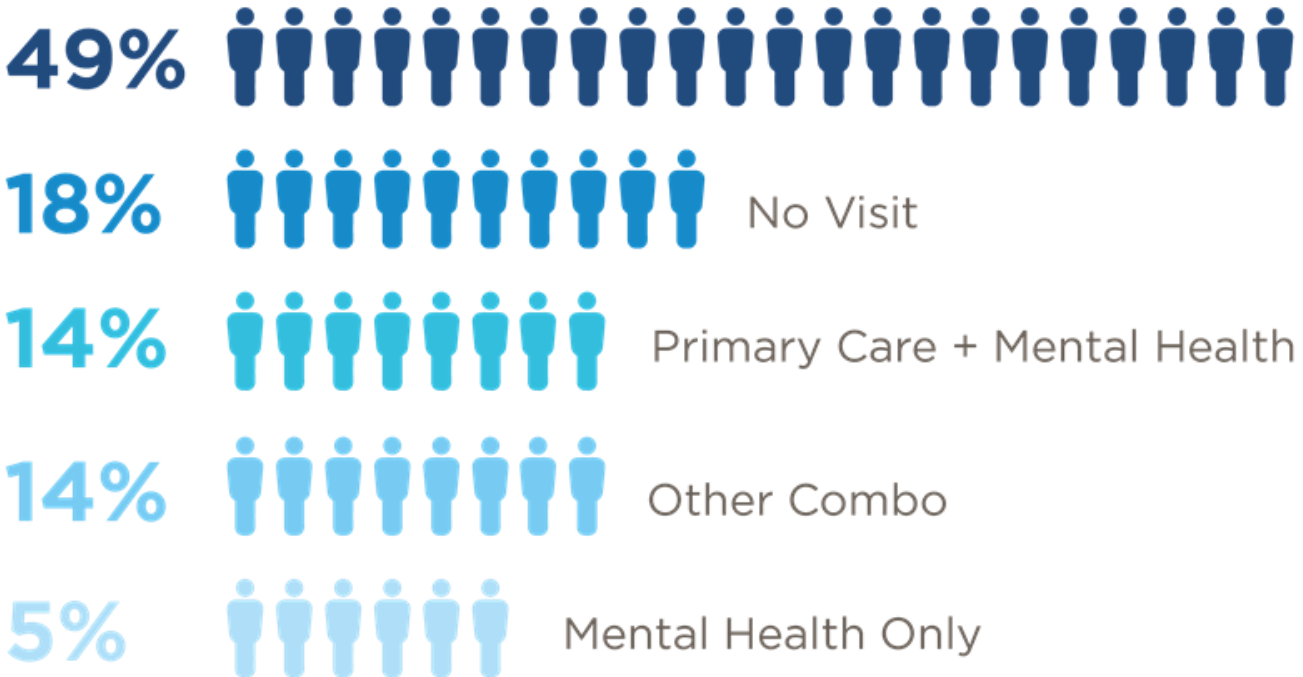
20%
24 Hours

73%
Elderly – 1 Month

Luoma, Martin, & Person, 2002; Pirkis & Burgess, 1998; Juurlink et al., 2004

MENTAL HEALTH TREATMENT PATHWAYS

Visits for Individuals with Poor Mental Health



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

Peterson, S., Miller, B., Payne-Murphy, J., & Phillips, R. (2014). Mental health treatment in the primary care setting: patterns and pathways. Family, Systems, & Health.

Fragmentation is Costly

	Annual Cost – those without MH condition	Annual Cost – those with MH condition
Heart Condition	$4,697	$6,919
High Blood Pressure	$3,481	$5,492
Asthma	$2,908	$4,028
Diabetes	$4,172	$5,559

Petterson S, Phillips B, Bazemore A, Dodoo M, Zhang X, Green LA. Why there must be room for mental health in the medical home. *American Family Physician.* 2008;77(6):757.

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

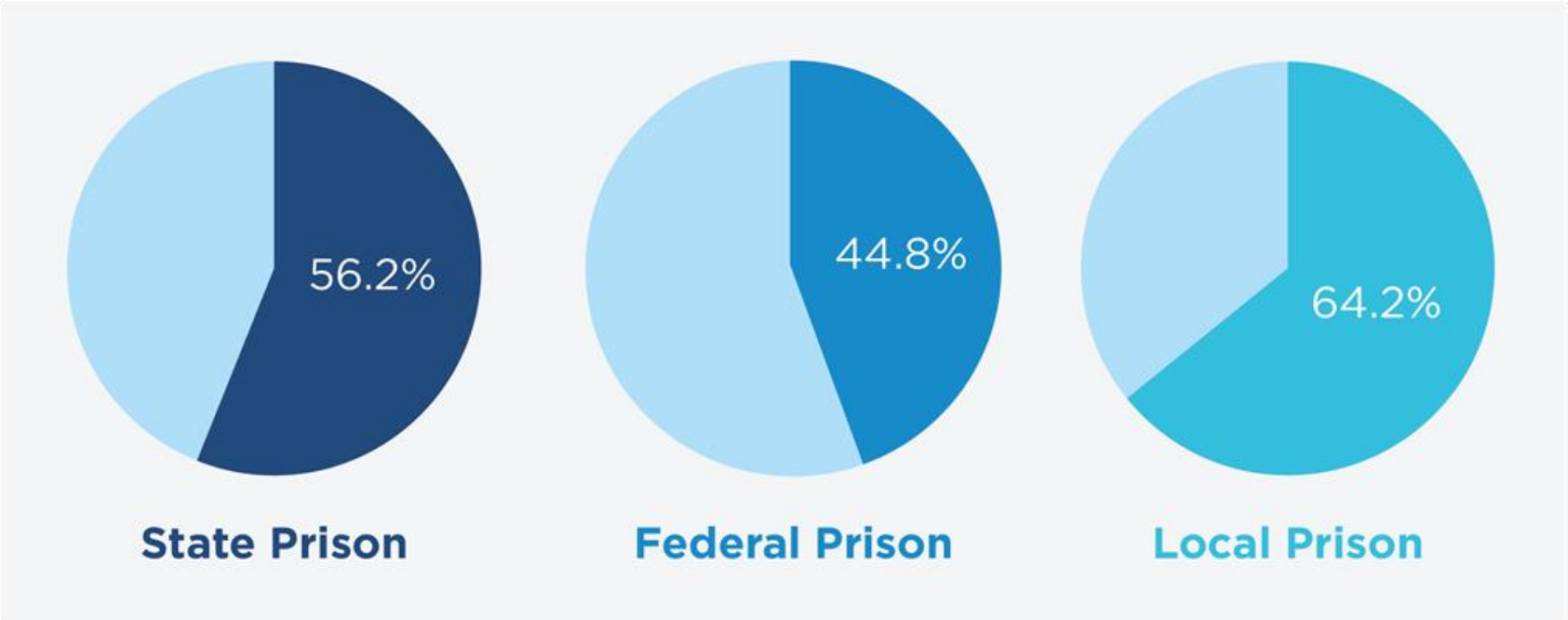
Kolko, D. J., et al. (2014). "Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial." Pediatrics **133**(4): e981-e992.

Figure 1: Projected Healthcare Cost Savings Through Effective Integration (National, 2012)	
Payer Type	**Annual Cost Impact of Integration**
Commercial	$15.8-$31.6 billion
Medicare	$3.3-$6.7 billion
Medicaid	$7.1-$9.9 billion
Total	**$26.3-$48.3 billion**

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.[1] 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.

THE NEW DE FACTO MENTAL HEALTH SYSTEM

Inmates meeting criteria for mental health problem within previous year



Approximately

State

Federal

Local

Received mental health treatment since admission

U.S. Department of Justice. (2006, September). Mental Health Problems of Prison and Jail Inmates. *Bureau of Justice Statistics Special Report.*

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

Alignment requires shared vision

WHAT DO YOU WANT YOUR MENTAL HEALTH SYSTEM TO BECOME?

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)**

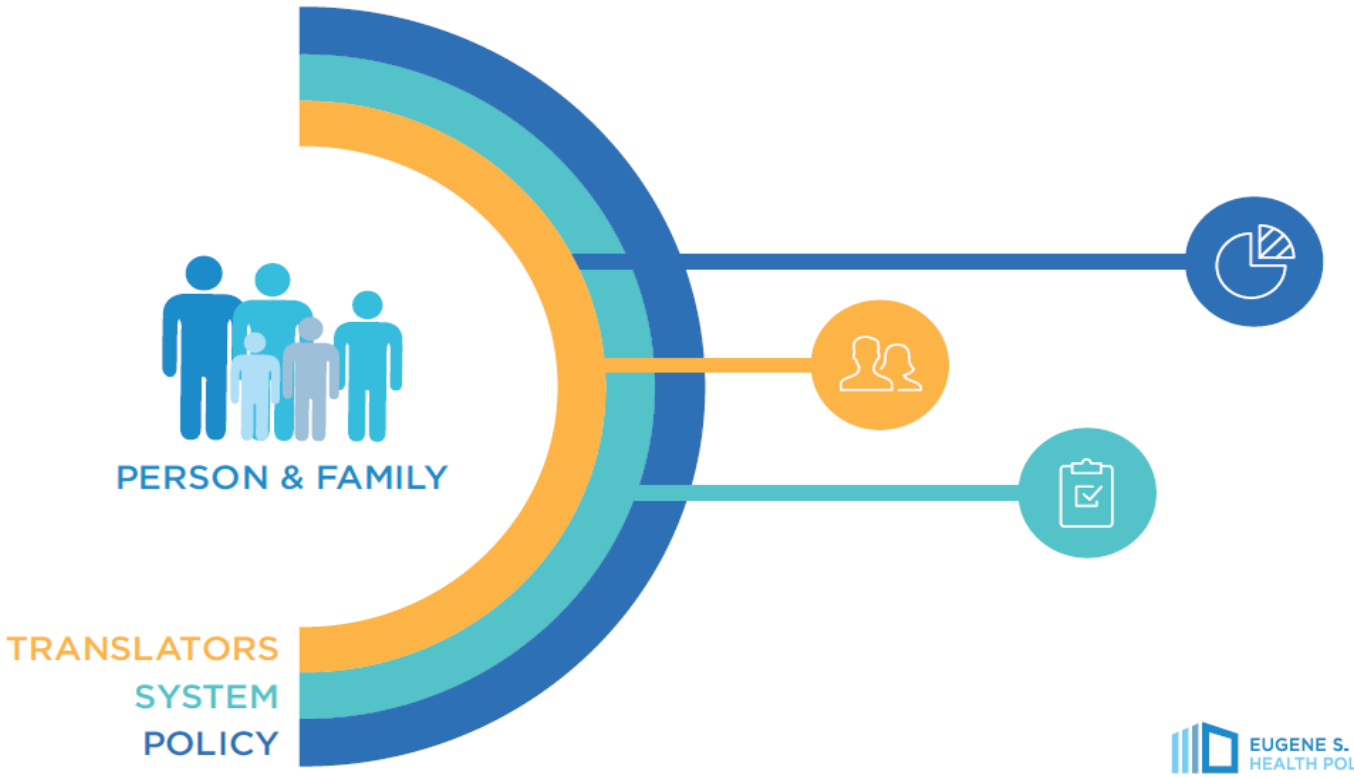
What we need to do moving forward

ASK

James Baldwin

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

CONCEPTUAL FRAMEWORK



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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

WHAT is covered?

What is the
LEVEL OF PAYMENT?

What is the
FORM OF PAYMENT?

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HEALTH POLICY CENTER

farleyhealthpolicycenter.org

Questions?

BENJAMIN.MILLER@UCDENVER.EDU
BEN@WELLBEINGTRUST.ORG