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National Council for Behavioral Health

Healthcare Reform: Implications for Behavioral Health Provider Community

Chuck Ingoglia, Senior Vice President, Public Policy & Practice Improvement

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National Council for Behavioral Health

- **Represents over 2,000 community organizations that provide safety net mental health and substance abuse treatment services to over six million adults, children and families**
- **National voice for legislation, regulations, policies, and practices tl protect and expand access to effecti mental health and addictions service**

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Educate and Advocate

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The greatest danger in times of turbulence is not the turbulence. It is to act with yesterday's logic.

Peter Drucker

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Overview: Our Hypothesis...

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- We have reached the tipping point in understanding the importance of treating the **healthcare needs of persons with serious mental illness and the behavioral healthcare needs (MH/SU/COD) of all Americans...**
- Due to an expanding awareness of the **prevalence of behavioral health disorders** and the **Total Healthcare Expenditures** associated with individuals with MH/SU/COD disorders
- This has the potential to **dramatically alter the treatment landscape** for individuals with co-occurring disorders and the organizations that serve them

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Overview: Healthcare Reform...

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May actually result in...

- Moving further upstream with **prevention & early intervention** services to prevent health conditions from becoming chronic health conditions

Reducing **errors and waste** in the system and **reducing incentives** for high cost, low value, procedure-based care

Dramatically improving the **management of chronic health conditions** for Americans with one or more such conditions

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But wait...

Developing Welcoming Systems for Individuals with Co-Occurring Disorders: The Role of the Comprehensive Continuous Integrated System of Care Model

Kenneth Minkoff, MD
Christie A. Cline, MD

People with co-occurring psychiatric and substance use disorders frequently present in both substance treatment and mental health service systems and are associated with poorer outcomes and higher costs in multiple domains.[1,2] In addition, these individuals have historically been poorly served in both mental health and substance abuse treatment systems, both because of a lack of information on effective treatment programs and interventions, and because of significant systemic barriers in both systems. These system barriers are striking in that these individuals–in spite of their poor outcomes and high cost–are not only not prioritized and specifically welcomed, they are experienced as "misfits" at every level–at the system policy level, at the program design level, at the clinical practice level, and at the clinician competency and training level–in terms of regulations, information systems, funding mechanisms, and clinical credentialing and certification.

Kenneth Minkoff, MD
Christie A. Cline, MD

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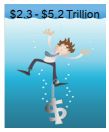
Looking through the Lens of 3 Questions

- Question 1: Will healthcare reform really change the healthcare system?
- Question 2: If healthcare reform results in the shift from a sick care system to a health care system, how will this affect Americans with co-occurring disorders and the organizations that serve them?
- Question 3: But will all these great ideas really work for Americans with co-occurring disorders?



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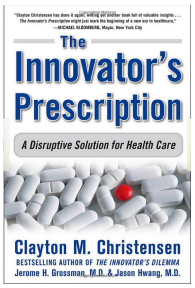
Question 1: Will healthcare reform really change the healthcare system?



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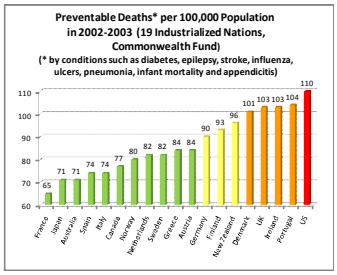
Connecting the Dots

The U.S. Healthcare System is both the *Best* and the *Worst* Healthcare System in the Industrialized World



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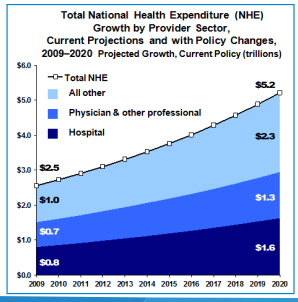
Connecting the Dots

The Cost Growth of the current American Healthcare System is unsustainable

Growing at a rate much higher than the rest of the Economy



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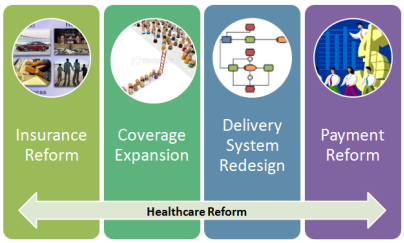
Strategies at a Glance...



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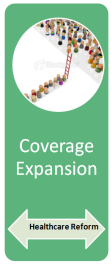
Coverage Expansion: The Accountable Care Act

- Requires Coverage for most Americans
- Provides Credits & Subsidies up to 400% FPL
- Employer Coverage Requirements (>50)
- Small Business Tax Credits
- Creates State Health Insurance Exchanges
- Expands Medicaid
- Addresses $1,000 per year of Uncompensated Care embedded in Private Insurance policies



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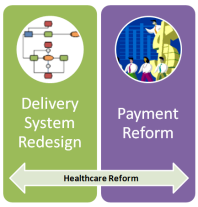
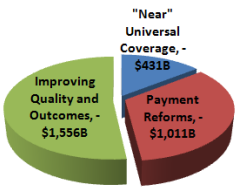
Service Delivery Redesign and Payment Reform

The Commonwealth Fund's The Path to a High Performance U.S. Health System Identifies 10 Health Care Reform Policies that can save $3 trillion over 10 years (**Commonwealth Fund 2009**)





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Everyone has their eye on... The Group Health Cooperative Story

- **2002-2006: Move towards Medical Home**
  - Email PCP
  - Online Medical Records
  - Same Day/Next Day Appointment

  (Increased patient access but also saw provider burn-out and decline in HEDIS scores)
- **2007: More robust Healthcare Home Pilot**
  - Added more staff (15% more docs; 44% more mid-levels; 17% more RNs; 18% more MAs/LPNs; 72% more pharmacists)
  - Shifted to 30 minute PCP slots

  (Reduced burnout, increased HEDIS scores, broke even in the first year)

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Joint Principles of the Patient-Centered Medical Home (www.pcpcc.net)

- Ongoing Relationship with a PCP
- Care Team who collectively takes responsibility for ongoing care
- Provides all healthcare or makes Appropriate Referrals
- Care is Coordinated and/or Integrated
- Quality and Safety are hallmarks,
- Enhanced Access to care is available
- Payment appropriately recognizes the Added Value

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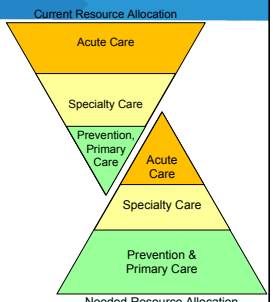
The Elephant in the Living Room

- Need to invert the Resource Allocation Triangle
- Prevention Activities must be funded and widely deployed
- Primary Care must become a desirable occupation and
- Decrease Demand in the Specialty and Acute Care Systems
- These are dramatic shifts that will not *magically* take place



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Two Types of Payment Reform are the Key

Value-Based Purchasing (VBP)

Value-Based Insurance Design (VBID)

Need to save for another conversation…

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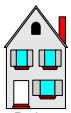
Value-Based Purchasing – Medical Homes

- Fee for Service is headed towards extinction
- Health Care Home models are beginning with a 3-layer funding design with the goal of the FFS layer shrinking over time
- Being replaced with case rate or capitation with a pay for performance layer



Patient Centered Medical Homes

Case Rate	· Prevention, Early Intervention, Care Management for Chronic Medical Conditions
Fee for Service/ PPS	· Per Service Payment · Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls
Bonus	· Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)

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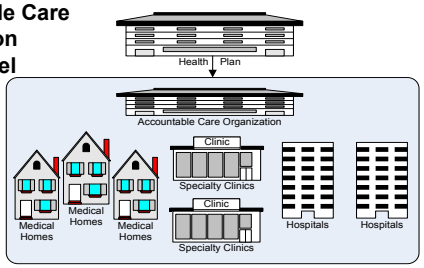
Accountable Care Organizations (ACOs) – *the homes for medical homes*

Accountable Care Organization (ACO) Model



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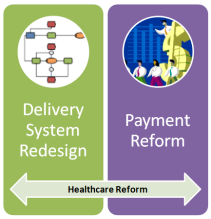
Service Delivery Redesign and Payment Reform



- $700 Billion Question: Will the current healthcare reform law and accompanying payment reform & delivery system redesign *tools* be enough to improve quality and bend the cost curve before healthcare costs bankrupt us?
- Our Prediction: Not unless the healthcare system addresses the needs of individuals with MH/SU and/or COD

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Question 2: If healthcare reform results in the shift from a sick care system to a health care system, how will this affect Americans with a behavioral health disorders and the organizations that serve them?

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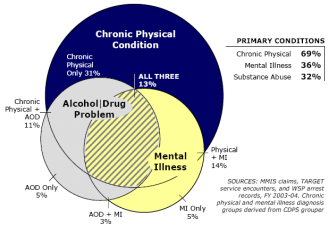
The Missing "Dot"

Mental Health, Substance Use, and Co-Occurring Disorders: an inseparable part of the equation

Co-occurring Diagnoses and the GA-U Population

52 percent had **substance abuse** or **mental illness** identified

31 percent had a **chronic physical condition** only



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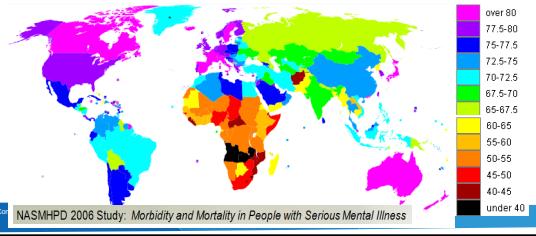
The Consequences for Americans with a SMI and a COD

- The 53 year lifespan for Americans with a Serious Mental Illness is comparable with Sub-Saharan Africa
- Americans with a COD are dying, on average, at age 45 (Oregon Department of Human Services Addiction and Mental Health Division, June, 2008)



NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*

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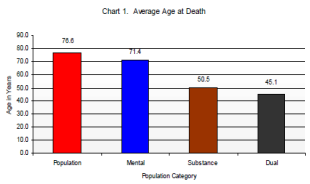
The Consequences for Americans with a SMI and a COD

- **While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)**
- **OR state study found that *those with co-occurring MH/SU disorders* were at greatest risk (45.1 years) (Oregon Department of Human Services Addiction and Mental Health Division, June, 2008)**



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The Consequences for the Overall Healthcare System

California Fee for Service Medi-Cal Analysis - 2007

	Medi-Cal FFS Total	Medi-Cal FFS SMI		Metric
Medi-Cal FFS Enrollees	1,580,440	166,786	11%	SMI % of Total
Medi-Cal FFS Costs	$6,186,331,620	$2,395,938,298	39%	SMI % of Total
Medi-Cal FFS Cost/Enrollee	$3,914	$14,365	3.7	SMI/Non-Ratio
Diabetes	4%	11%	2.8	SMI/Total-Ratio
Ischemic Heart Disease	2%	6%	3.0	
Cerebrovascular Disease	1%	3%	3.0	
Chronic Respiratory Disease	5%	13%	2.6	
Arthritis	2%	7%	3.5	
Health Failure	1%	3%	3.0	
Inpatient Episodes/1,000	100	293	2.9	SMI/Total-Ratio
ER Visits/1,000	337	1,167	3.5	
Inpatient Acute Days/1,000	609	2,094	3.4	
Primary CareVisits/1,000	128	492	3.8	
Specialist Visits/1,000	1,211	6,058	5.0	

Data from JEN Associates, Cambridge, MA

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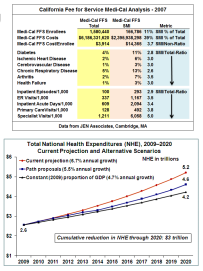
Alignment of the Stars for Persons with MH/SU/COD Disorders

- Growing awareness of the prevalence of MH/SU disorders and the cost of not providing effective treatment and supports
- Combined with parity and the increased risk of near universal coverage for the safety net population
- Combined with the an awareness that
  - Behavioral Health is necessary for Health
  - Prevention is Effective
  - Treatment Works
  - People Recover
- Results in increasing recognition that we can't bend the curve without addressing the healthcare needs of persons with a SMI and the MH/SU needs of all Americans



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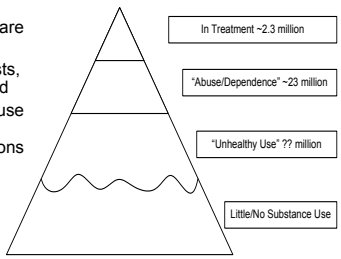
The Other Elephant in the Living Room

- SU conditions are prevalent in primary care
- SU conditions add to overall healthcare costs, especially for Medicaid
- SU conditions can cause or exacerbate other chronic health conditions
- SU interventions can reduce healthcare utilization and cost



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But did the authors of the Accountable Care Act understand these things?

- Short Answer: **Yes**
- Longer Answer:
  - **Parity in Medicaid Expansion:** Expands Medicaid Eligibility to all Americans up to 133% of federal poverty, and requires coverage of mental health and substance use disorder services for all newly eligible parents and childless adults and existing persons in Medicaid managed care programs
  - **Parity in the Exchanges:** The ACA requires a basic benefit package that requires coverage of mental health and substance use disorder services for all health plans operating in the new Health Insurance Exchanges (for newly insured and those coming in from the individual and small-group markets)

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Type of Plan	Must offer MH/SUD?	Parity applies?
Plans sold in Exchanges (Qualified Health Plans)	✓	✓
Individual market (not sold in the Exchanges)	✓[1]	✓
Small group market (not sold in the Exchanges)	✓[1]	✓[2]
Large group market (not sold in the Exchanges)	⊘	✓[3]
Traditional Medicaid, fee-for-service	⊘	⊘
Traditional Medicaid, managed care	⊘	✓[3]
Benchmark Medicaid for newly eligible, FFS	✓	Partially[4]
Benchmark Medicaid for newly eligible, mgd care	✓	✓

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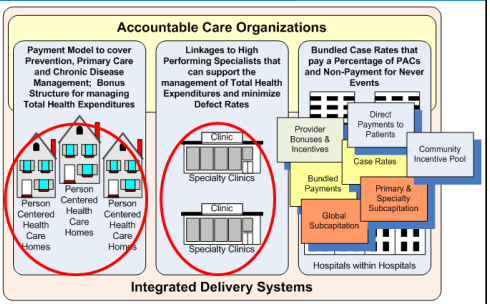
What are the implications for Organizations that provide COD Services?



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"Customization" of Medical Homes

- Analogy: Generic Hospital Beds and ICU
- Customization of Medical Homes – different models for different needs
  - Seniors in nursing homes
  - Youth in Families receiving TANF
  - Adults with a SMI
  - Inuits in rural Alaska
- Person-centered healthcare homes in MH/SU/COD clinics will be one of many designs used to bend the cost curve

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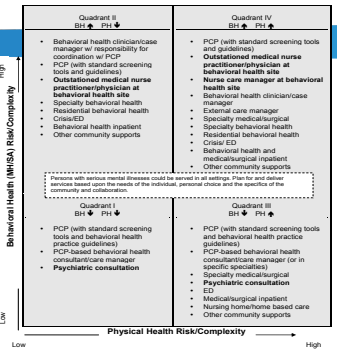
The Four Quadrant Clinical Integration Model

Each quadrant considers the behavioral health and physical health risk and complexity (low to high) of the population

Generally…

Persons in Quadrants I and III should receive BH services in Primary Care

Persons in Quadrants II and IV should receive PC services in Behavioral Health



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The Person-Centered Healthcare Home: Quadrants I and III

Q I

- PCP
- PCP-based BHC/care manager
- Specialty prescribing consultation
- Wellness programming
- ED based MH/SU/COD interventions

Q III

- PCP
- PCP-based BHC/care manager
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- ED based MH/SU/COD interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

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The Person-Centered Healthcare Home: Quadrants II and IV

Q II

- Outstationed medical NP/PCP
- BH clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU/ COD treatment including medication-assisted therapy
- Residential SU/COD treatment
- Crisis/ED based MH/SU/COD interventions
- Detox/sobering
- Wellness programming
- Other community supports

Q IV

- Outstationed medical NP/PCP
- Nurse care manager/BH site
- BH clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU/COD tx
- Residential SU/COD treatment
- Crisis/ED based MH/SU/COD interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

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MH/SU/COD Customization: Person-Centered Healthcare Homes

The IPI Continuum: A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population

	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
	• Screening and assessment of commonly presenting MH/SU	→	→	→
Optimal MH/SU services for each MH/SU level, for all ages (children, youth, adults, older adults)	• Care management as needed • Self management goal setting (for MH/SU and physical health conditions) education, activation	• Care management/registry tracking of those receiving services • Self management goal setting (for MH/SU and physical health conditions) education, activation and relapse planning	• Care management/registry tracking of those receiving services • Assessment and monitoring of key health indicators[3] • Self management goal setting (for MH/SU and physical health conditions) education, activation and relapse planning	• Care management/registry tracking of those receiving services • Assessment and monitoring of key health indicators[3] • Self management goal setting (for MH/SU and physical health conditions) education, activation and relapse planning/Wellness Management and Recovery
	• Brief problem-oriented counseling/therapy • Prescribing • "Watchful waiting" • Stepped care (changes in the types and intensity of services, medications) within this level or to another level	• Brief treatment of MH conditions, crisis plan • Prescribing • Pain Clinic • Psychiatric consultation for care manager/PCP • Stepped care (changes in the types and intensity of services, medications) within this level or to another level	• Risk assessment and crisis plan • Person-centered treatment plan • Treatment of MH disorders using evidence-based practices • Prescribing • Psychiatric consultation for care manager/PCP	• Risk assessment and crisis plan • Person-centered treatment plan • Intensive Case Management Team/Assertive Community Treatment[2] • Family Psychoeducation • Supported Education • Supported Employment • Consumer-Operated Service Programs

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Behavioral Health Customization: Person-Centered Healthcare Homes

Bi-Directional Care: Behavioral Health in Primary Care *and* Primary Care in Behavioral Health

Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity

Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service

Partnership/ Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity

Community Behavioral Healthcare Organization with an **embedded Primary Care Medical Clinic** with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity

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Bi-Directional Primary Care/SU Services

SU Services in Primary Care

- Diffusion of screening and brief intervention (SBI) is underway
- Motivational interviewing with fidelity should be a consistent component of SBI
- Repeated BI in primary care is a promising practice
- Medication-assisted therapies in primary care can be expanded

Primary Care in SU Settings

- Many individuals served in specialty SU have no PCP
- Health evaluation and linkage to healthcare can improve SU status
- On-site services are stronger than referral to services
- Housing First settings can wrap-around MH, SU and primary care by mobile teams
- Person-centered healthcare homes can be developed through partnerships between SU providers and primary care providers
- Care management is a part of SU specialty treatment and the healthcare home

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Question 3: But will all these great ideas really work for Americans with behavioral health disorders?

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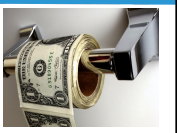
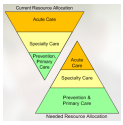
But will all these great ideas really work?

- Short Answer: **We don't know...**
- Longer Answer:
  - We really have no choice economically and...
  - We have the knowledge and technology to invert the resource triangle and move from a sick care to a health care system for persons with a co-occurring disorder, but...





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Healthcare Reform will occur... but...

- **All Healthcare is Local...**
- **COD Provider Organizations will need to:**
  - Promote the Business Case for addressing the needs of Americans with a co-occurring disorder
  - Prepare to integrate with primary care and demonstrate that they can improve quality and help manage the total healthcare expenditures of the clients they serve

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Questions?

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