Fixing Mental Health Care in America

A National Call for Integrating and Coordinating Specialty Behavioral Health Care into the Medical System

An Issue Brief Released by The Kennedy Forum

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EXECUTIVE SUMMARY

One in four individuals will struggle with a mental health or substance use disorder at some point in their lives, and these disorders are responsible for nearly 25% of all disability and substantial increases in overall health care costs. Although effective treatments exist for most behavioral health conditions, many people don't receive the care they need due to lack of access, poor quality care, and ineffective coordination between the medical and behavioral systems.

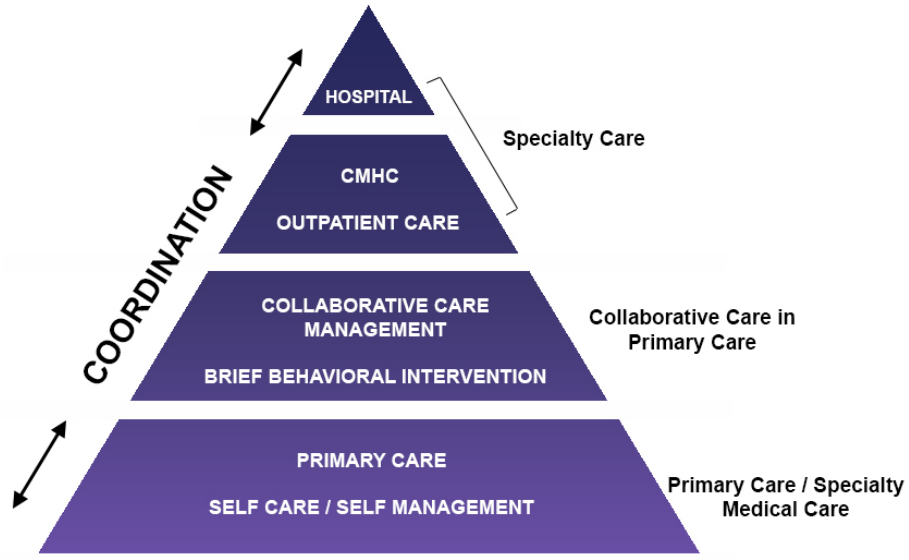
Data from the National Comorbidity Study show that access to behavioral health treatment is limited. Only 40% of people with a mental health or substance use disorder receive treatment in any given year, meaning that 60% of people are not getting any treatment at all. Only 12% receive care from a psychiatrist, and only 22% receive care from any mental health specialist. Slightly more (23%) are treated by a primary care provider or other general medical provider.

While barriers from long wait times to cost and stigma surrounding mental illness help explain why so few people access specialty care, the reality is that the specialty mental health care system is underequipped to treat the vast number of people with mental health and substance use disorders. More than half of counties in the US do not have a single practicing mental health professional, a problem particularly acute in rural areas. Primary care has become the *de facto* location for these patients to receive treatment, but unfortunately, the majority of their care is ineffective. Only 13% of people diagnosed with a behavioral health condition receive minimally adequate treatment in a general medical setting; for substance abuse alone, that number drops to a dismal 5%. Numerous studies show that primary care providers often do not have the time or resources to provide effective treatment for many behavioral health conditions that present including depression, anxiety disorders, posttraumatic stress disorder, substance use, and bi-polar disorder. Less than 20% of primary care providers feel "very prepared" to identify substance use disorders, and most patients with a substance use disorder say their primary care provider did nothing to address their disorder. For the 30 million people who receive an antidepressant each year in primary care, only 25 % show substantial clinical improvement.

Conversely, many patients with serious mental illness (SMI), including schizophrenia, bipolar disorder, and schizoaffective disorder, who are seen in behavioral health homes are not getting effective medical care. Patients with SMI die at rates two to three times higher than in the general population. This

translates to a 13-30 year shortened life expectancy in SMI patients, and recent evidence suggests this mortality gap is worsening. The implications of untreated medical conditions in specialty mental health combined with untreated behavioral health conditions in primary care are enormous, leading to missed suicide warnings, clogged emergency rooms, high hospital readmission rates, and structural and financial strains on the entire health care system. Patients with mental health and substance use disorders have two to three times higher overall health care costs than those without.

No one part of the health care delivery system is equipped to provide effective care for all those with behavioral health problems. Although improvement is needed across the entire spectrum, especially in terms of the coordination of handoffs and improved medical care for SMI patients, **strengthening the behavioral health care services in primary care is critically needed for three reasons: 1) the majority of people with behavioral health conditions get their care in primary care; 2) the quality of behavioral health care in primary care is substandard; and 3) effectively treating patients with behavioral health conditions offers enormous cost savings.**



Task Sharing in Behavioral Health Care

Researchers and clinicians have looked at ways to improve the detection and treatment of mental health disorders in primary care settings for over thirty years. Efforts initially focused on screening for common mental disorders, co-location of mental health providers in primary care clinics, provider education and training, facilitated referral to mental health specialty care, and disease management. These approaches – alone and in combination – have not been found to improve patient outcomes. **Although other promising approaches are emerging, the Collaborative Care model has the most robust evidence for effective integration of behavioral health care into primary care.**

COLLABORATIVE CARE

Collaborative Care is a specific type of integrated care that treats common mental health and substance use conditions such as depression and anxiety in primary care settings. In usual primary care, the treatment team has two members: the primary care provider and the patient. Collaborative Care adds two additional vital roles: a care manager (typically embedded) and a psychiatric consultant (typically engaged by phone or tele-video link). Collaborative Care is:

- *Measurement-based*, with screening and monitoring of patient-reported outcomes over time to assess treatment response;
- *Team-based*, led by a primary care provider with support from a care manager and consultation from a mental health specialist who provides treatment recommendations for patients who are not achieving clinical goals;
- *Population-based,* whereby the care team uses a registry to monitor treatment engagement;
- P*atient-centered*, with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services;
- E*vidence-based,* with demonstrated cost-effectiveness in diverse practice settings and patient populations*;*
- P*ractice-tested,* with sustained adoption in hundreds of clinics across the country; and
- *Accountable* for the care provided and for continuous quality improvement to meet care goals.

Evidence Base

The evidence behind Collaborative Care is clear and compelling. **More than 80 randomized controlled trials have shown Collaborative Care to be more effective than usual care for common mental health conditions such as depression and anxiety.** Collaborative Care has been further substantiated by several recent meta-analyses, including a 2012 Cochrane Summary that reviewed 79 randomized controlled trials and 24,308 patients worldwide. Collaborative Care has been developed in multiple settings and in multiple research protocols in the US and around the world. The research is particularly strong for depression but increasingly for other conditions as well including anxiety disorders, posttraumatic stress disorder, and co-morbid medical conditions such as heart disease, diabetes and cancer. Research shows Collaborative Care improves patient functioning at home and at work, reduces disability, improves clinical outcomes, and increases patient satisfaction and quality of life.

The evidence on Collaborative Care for substance use disorders is more limited and somewhat mixed. Some mature Collaborative Care programs handle a variety of substance use disorders, and there is some practice evidence that screening, brief interventions, and referrals (the first three parts of the SBIRT approach) can be handled within primary care. Given that many patients who have a substance use disorder also suffer from anxiety or depression, Collaborative Care's demonstrated impact on those conditions can, at minimum, reduce the suffering among patients who suffer from those comorbid conditions.

Collaborative Care not only improves patient care experiences and health outcomes, it also reduces overall health care costs. Results from the largest trial of Collaborative Care to date, the IMPACT study for depression care which was tested for older adults treated in primary care clinics in five states, found substantial reductions in long term overall health care costs in patients who had received Collaborative Care. The overall return on investment was $6 in health care costs saved for each dollar spent on depression care. **In short, there is extensive evidence that Collaborative Care for common behavioral health conditions results in improved clinical outcomes, increased patient satisfaction, and reduced overall health care costs, the Triple Aim of health care reform**.

OVERALL RECOMMENDATIONS

In 1948, the World Health Organization defined health as "a state of complete physical, mental and social well-being and not simply the absence of disease." More than 75 years later, our medical system continues to treat the mind and body separately without regard for the needs of the patient. The absence of integrated behavioral and medical healthcare poses a serious health risk to millions of patients and needs to be remedied.

The Kennedy Forum strongly endorses the following policies:

1. **Primary care clinics that want to treat patients with common mental health disorders should implement the Collaborative Care model due to its proven effectiveness in improving clinical outcomes, increasing patient satisfaction, and lowering overall health care costs.**
2. **Primary care clinics that want to treat patients with substance use problems should incorporate evidence-based brief interventions, such as SBIRT or**

medication assisted management, into Collaborative Care models to improve the outcomes for the many patients with addictions.

3. **Specialty mental health care that treat patients with severe and persistent medical illness should integrate and/or coordinate with the general medical system to enhance the treatment of the medical conditions of these patients. Those models that show a positive evidence-base should be expanded.**
4. **All parts of the health care system should provide effective coordination of care and handoffs for the patients they serve who have mental health and substance use problems. For example, someone who is discharged from an emergency room or a psychiatric hospital needs effective follow-up, and programs should assure that referrals to effective behavioral care are successfully completed.**

The main barriers to achieving the above recommendations are 1) absence of a payment structure that supports evidence-based practices for treating mental health and substance use disorders in primary care, 2) lack of a large enough mental health workforce skilled in supporting primary care providers, and 3) resistance to the substantial practice change necessary to implement Collaborative Care. The Kennedy Forum offers the following recommendations:

Payers and Purchasers

Under standard fee-for-service payment models, key components of effective integrated care approaches like Collaborative Care are generally not reimbursable. In the absence of payment reform, payers, purchasers and regulators need to remove payment obstacles to and improve reimbursement for evidence-based approaches in primary care. Reimbursements should focus on the key elements of effective integrated care including care management services, use of standardized outcomes measures, and the regular caseload review and consultation by a designated psychiatric consultant, typically done by phone or video. This can be done by monthly case rates or by a fee for service mechanism that properly reimburses for such services as care management and psychiatric case review/consultation. Capitated, episode of care, and pay for performance reimbursement environments also need to support effective integrated care. Payers and purchasers should partner with practices to help implement evidence-based approaches, use Quality Improvement methods to track health and cost outcomes and

to foster competition and best practices, and incentivize components of effective integrated care. Payers and purchasers should track program-level health and cost outcomes by requiring practices to use a disease management registry, and push for registries that are compatible with Electronic Health Records. Payers such as CMS should support the practice change necessary to implement Collaborative Care.

Regulators can also help push evidence-based integrated care programs by setting standards for integrated care. For example, the National Committee for Quality Assurance (NCQA) has started to incorporate integrated care requirements as part of their Patient Centered Medical Home accreditation. The National Committee for Quality Assurance (NCQA) has proposed depression symptom monitoring and outcomes as health plan performance measures for the 2016 Healthcare Effectiveness Data and Information Set (HEDIS). These types of efforts should be strengthened, and the Kennedy Forum is recommending that all payers use standardized MHSUD measures in their ACOs and Primary Care medical homes.

Providers and Provider Organizations

Collaborative Care has many benefits to medical providers including better patient outcomes, increased patient satisfaction, and lower overall health care costs. Providers, especially medical systems, should understand the prevalence of mental health disorders of patients in their care and the local implications for health outcomes and health care costs. They need to negotiate financial support for implementing evidence-based approaches to integration, such as Collaborative Care, tailored to their unique practice settings and patient populations. Additionally, providers need to track clinical outcomes at a patient and provider level to make sure stated goals are being met by comparing their data to the scientific literature and/or similar organizations for benchmarks. The American Association of Family Physicians recently released a report stating that improving mental health treatment requires enhancing the ability of the primary care physician to screen, treat and appropriately manage the psychiatric care given to patients and advocated several principles to support their position. The American Medical Association and the American College of Physicians should follow suit.

Mental health care providers should understand the value of population-level care, learn the skills necessary to become an effective consultant in primary care and should seek out opportunities to become part of a Collaborative Care team.

Future and current workforce training programs

There are many points in health professional training where integrated care awareness and skills should be part of the training program. Health professional schools should introduce the importance of health behavior and behavioral health care early on in training, and academic medical centers and affiliated teaching practices should provide opportunities for interdisciplinary and team-based training in effectively integrated behavioral health care. Psychiatry residency programs should develop strong training programs in evidence-based integrated care as was recently recommended by the American Psychiatric Association. Training the existing workforce is equally as important and opportunities are needed that focus on the knowledge, skills and attitudes necessary to help psychiatrists provide high quality care for larger populations. Finally, accreditation programs such as the AAMC and ACME should require interdisciplinary training in effectively integrated care for mental health specialists and primary care providers.

Patients and Patient Advocacy Groups

Behavioral health and consumer advocates should educate consumers about effective treatments and how to ask for better care. Patients and their family members should understand the value of well-integrated care, demand that measurement-based care be implemented, ask for Collaborative Care programs, and expect effective treatment and remission from their symptoms.