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Early stages of a long process

Hospital, School of Medicine Set to Take on Behavioral Health Challenge

By Tyler Smith

Think about having a serious injury or illness that causes you severe pain. You get some powerful painkilling medications that give you temporary relief, but the discomfort is a constant companion. Work becomes a challenge. The depression you've managed to deal with for a good portion of your life deepens. Your reliance on the pain medications grows to the point that you become addicted, and you let your physical health slide. Eventually you're caught in a quagmire of physical and mental health issues complicated by a substance abuse disorder (SUD).

Federal SIM grant money promises to help the hospital get its behavioral health service line up and running.

Now you decide to get some help. Ideally you'd get treatment in a health care system that recognizes that your issues are related and addresses not only your underlying physical problem but also your depression and SUD. Unfortunately, your primary care physician doesn't feel equipped to address behavioral health or SUDs – and you don't feel comfortable talking about them with a medical provider. As a result, your problems worsen.

It's a scenario all too often played out in various permutations in a fragmented health care world that regards primary care, behavioral health, and SUD treatments as realms onto themselves. The result: episodic care that at best creates inefficiencies and waste, and at worst leaves patients bereft of the services they need to lead healthy lives.

There are signs, however, that the calculus is changing among hospitals and health care systems that recognize the close relationships between the three. Among them is University of Colorado Hospital, which is in the very early stages of building an integrated behavioral health service line.

Linking arms. The effort brings to the table leaders from the hospital's primary care and outpatient psychiatric clinics, the School of Medicine's departments of Family Medicine and Psychiatry, and the Center for Dependency, Addiction and Rehabilitation (CeDAR), all of whom have assumed prominent roles in figuring out how to build a coordinated model from the disparate clinical pieces that exist today. They will also work closely with representatives from Finance, Emergency Medicine, Payer Relations, and Nursing, among many others.

In one important way, the time is ripe. Colorado is receiving $65 million for a federally funded State Innovation Model (SIM) grant to integrate mental health services in primary care physicians' offices. As the Department of Family Medicine has been a leader in that work with projects such as Advancing Care Together, some of the grant money figures to be available to seed the new service line at UCH.

The idea behind a behavioral health service line is straightforward, said UCH Chief Operating Officer Tom Gronow. "We want to be able to intervene before an acute [mental health] episode and get patients care from a social worker, a psychologist, a psychiatrist, or an addiction specialist, depending on the situation," he said.

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"We're trying to develop integrated services within primary care that address the needs of patients holistically."

Ways to pay. A major challenge is to change the way insurers think about and pay for mental health services, which have traditionally been "carved out" from medical care, paid for separately – and at lower rates – and subject to an array of co-pays, limits, preauthorization requirements, and restrictions. A behavioral health service line could change that equation, Gronow said, with the hospital taking on the risk of managing patients for a defined amount.

The behavioral health service line is predicated on the notion that primary care, behavioral health care and substance abuse disorder treatments are intertwined.

"To do that, we have to have a service line within primary care that is broad enough to demonstrate to payers that we can take on outcomes – that for this population of patients, we can decrease utilization, ED visits, drug use, chronic pain, and other ways behavioral health issues may manifest themselves," Gronow said.

"The knowledge or suspicion that whole-person care is better than fragmented care has been out there for 30 years," said Frank deGruy, MD, chair of CU's Department of Family Medicine. Now improved data gathering and outcomes measurement has enabled organizations like the Department of Defense and Knoxville, Tenn.-based Cherokee Health Systems to make the case that integrated care can accomplish the "triple aim" of improving the quality of care and the patient experience while managing costs, he said.

However, it will be a formidable task to build such a system because of issues of finance, resources, operations, and culture, deGruy emphasized, and the coming months will be spent addressing them. Chief among these is the question of how to reimburse the providers who contribute to integrated care. Putting psychologists in the same clinic as primary care physicians and having them consult with one another is important, but it doesn't constitute integration, deGruy said.

Lack of alignment. For example, in the hospital's AF Williams Family Medicine Clinic, behavioral health clinicians work side by side with physicians, deGruy said, in the interests of helping patients. But the clinic doesn't benefit financially from the arrangement; it simply absorbs the cost of the behavioral health providers.

"The quality of care we provide is real and measurable, but we are paying for the services out of pocket," deGruy said. "We have not yet created the means by which we can measure the savings we produce across the sectors of care and apply them most rationally."

Achieving that would require that various health care players align their interests, deGruy added. He gave the hypothetical example of primary care providers responsible for a panel of 2,000 patients who work closely with behavioral health clinicians to address mental health issues that could exacerbate their chronic conditions. They might be very successful in preventing unnecessary ED visits and hospitalizations, yet have little or nothing to show for the effort, deGruy said.

"If the hospital doesn't recognize those as savings, we're essentially spending our money to save the hospital money," he said.

Robert Feinstein, MD, vice chair of psychiatry clinical affairs and practice director for the hospital's Outpatient Psychiatric Clinic, said developing a payment system that replaces the fee-for-service model is the number-one issue in building a behavioral health service line – or any other approach that is based on coordinated, rather than episodic, care.

"There is no method to reimburse providers for integrated care," Feinstein said. "Once we figure out how to stop carve-outs and move to team-based care and value-based billing, the concept will flourish."

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Solution-resistant problem. In theory, at least, a behavioral health service line would function as a medical home that gives providers a financial incentive to manage and coordinate care cooperatively. But even if a payment structure magically came into place tomorrow, important barriers remain.

For one thing the demand for mental health and SUD services has exploded at a time that available resources are relatively scarce. Steve Millette, executive director for CeDAR, said an estimated 23 million people have an SUD, yet only about 7 percent get treatment.

"That's 19 million people clogging up the health care system," Millette said. "And many of them have a significant overlap with behavioral health issues. That's an important reason for non-compliance with their medical treatment."

In Millette's view, the hospital has many of the pieces needed to build an integrated service line. CeDAR, for example, has trained nurses, addiction medicine specialists, psychiatrists, and outpatient treatment for patients with SUDs. CeDAR and the Departments of Psychiatry and Family Medicine collaborate on two addiction medicine fellowships that include services at UCH, AF Williams, and Denver Health. The Outpatient Psychiatric Clinic offers on-site therapy and connects patients to community mental health services.

Much of the work that lies ahead will be pulling those elements into a coherent system that provides patients with screenings, appropriate interventions, and follow-up support, either through the hospital or community providers, Millette said.

That work will require changes in thinking from providers and the public, added Gary Kushner, CeDAR's director of operations. Too often, he said, treatment for SUDs is divided from treatment for mental health issues when in fact they are often co-occurring conditions.

"We tend to compartmentalize the disorders," he said. It's erroneously assumed, he said, that getting a person with a drug or alcohol problem sober will take care of his or her depression or other mental health issue. "One is not a symptom of the other," he said. "That's based on stigma, not science."

The behavioral health service line could help bring SUDs out of the shadows and make treatment of them a recognized component of recovery in the broadest sense, Millette said. But expanding access to services across the continuum of care is another difficult challenge, he added.

Beyond bricks and mortar. Overcoming it will require new approaches to delivering services. For example, the Outpatient Psychiatric Clinic today needs more capacity to handle a large new influx of patients. Feinstein said a key component of the behavioral health service line will be telehealth – remote consultations between behavioral health specialists, patients and/or their providers via webcams to supplement "bricks and mortar" services that will still be necessary, particularly for treatment of severe psychiatric issues.

Integrating SUD treatment at CeDAR will be a key component of the behavioral health service line strategy.

The Outpatient Psychiatric Clinic is "well set up" to provide telehealth services, Feinstein said, with 13 attending psychiatrists and computers, cameras, and headsets they use to observe residents' interactions with patients. The clinic also leads the development of the Epic behavioral health patient record system, which would be used to link telehealth services to University Physicians, Inc. billing.

The work on implementing the telehealth infrastructure is underway, with the goal of launching "lift-off" pilots with AF Williams and the Multiple Sclerosis Clinic in 2016, Feinstein said. Also in the works is a separate contract with private practices in underserved rural Colorado.

"The demand for telehealth in behavioral health is the most commonly requested service because of the limited access to behavioral health," Feinstein said. He also sees My Health Connection, Facebook, Twitter, and other social media outlets

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as important ways to exchange information with patients about mental health issues, new medications and treatments, ways to get care, and so on.

"It's a major way we could increase access to a continuum of mental health and SUD treatment services and programs as we integrate," Feinstein said.

Cultural questions. These are all necessary steps if the hospital is to overcome gaps in mental health resources that aren't likely to go away, even with an infusion of SIM grant funds. "There are lots of pieces needed to build an integrated system that can treat problems before they get out of control," Gronow said. "If we do it right, we can help to obviate the need for mental health beds. Like we do with diabetes, we want to prevent exacerbations for patients at the front end."

Family Medicine Department Chair Frank deGruy, MD, is a longtime proponent of integrating primary care and behavioral health services.

Improving patient access is vital, but building a successful service line also requires addressing cultural and operational issues, deGruy said.

"When you put different health care providers together, particularly those who grew up with different models of care, you wind up with certain inefficiencies," he said. "You need adaptive leadership to deal with that." For example, on one day, behavioral care specialists might have few patients to see, while on the next they are inundated. "There are leadership ways to deal with that and smooth that all out, but we are very early in that process," deGruy said.

Still, deGruy said he is optimistic about the growing level of support for building an integrated behavioral health model and the chance for UCH and the School of Medicine to become leaders in the endeavor.

"It's thrilling that the door is opening and the light is coming in," he said. "This is an opportunity we have never had before."