Evidence Based Practice: The benefits and challenges of behavioral health services in primary care settings.

Slides by Mark Friedlander, M.D., M.B.A.
Chief Medical Officer Aetna Behavioral Health

Anthony Rocchino, MSW
Sr. Director Network Management Aetna Behavioral Health

Angelo McClain, PhD, LICSW
Chief Executive Officer NASW

Troy Brindle, LCSW
Co-owner and Director Springfield Psychological
President of NASW-PA

Johanna Byrd, ACSW: Moderator
Executive Director NASW-PA
# Why Focus on Behavioral Health?

Mental health specialty care accounts for only 3% of overall costs

<table>
<thead>
<tr>
<th>Plan type</th>
<th>Percentage with BH diagnosis</th>
<th>PMPM without BH diagnosis</th>
<th>PMPM with BH diagnosis</th>
<th>Percentage Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>14%</td>
<td>$340</td>
<td>$941</td>
<td>276%</td>
</tr>
<tr>
<td>Medicare</td>
<td>9%</td>
<td>$583</td>
<td>$1429</td>
<td>245%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>21%</td>
<td>$381</td>
<td>$1301</td>
<td>341%</td>
</tr>
<tr>
<td>All payers</td>
<td>15%</td>
<td>$397</td>
<td>$1085</td>
<td>273%*</td>
</tr>
</tbody>
</table>

* APA Milliman report; Melek et al; 2013

- Mental illnesses account for 21.3 percent of all years lived with disability.
- An estimated 9.6 million American adults suffer from a serious mental illness. Those with SMI die 10 years earlier than individuals in the general population.
- 40,600 Americans die each year from suicide, twice the mortality for homicide or AIDS.
- Costs associated with mental illnesses exceed $300 billion/year
- Mental illnesses rank as the third most costly medical conditions in terms of overall health care expenditure, behind heart conditions and traumatic injury.

How We Got Here: Greater Demand

The Societal Context

• One in five children has a diagnosable mental disorder
• Reduced stigma, behavioral health is mainstream
• The chemical imbalance theory of mental illness as a brain disease
• Diagnoses are subjective and expandable, boundaries between normal and abnormal are often unclear
• Incentives promote use of medication over therapy
• The “medicalization” of behavior has blurred the boundary between “badness” and “madness,”
• “Epidemic” of substance misuse

Behavioral Health Landscape

• Regulatory environment: Parity, Affordable Care, Procedure Code changes.
• Overall BH trend is higher than medical trend, in part due to reduced stigma, increased media attention and advocacy related to addiction and mental illness.
• Despite the economic recovery, limited competition among providers drives utilization. Inflation seen in unit costs at all BH levels of care, especially out of network.
• Shortage of key specialties like child psychiatry, behavior analysts
• Direct to consumer advertising
• Single Shingle providers dominate
What Drives Costs? Where is the Value?

- Poly-chronic: 5% of the population, 45% of the cost
- Complex: 20% of the population, 35% of the cost
- Acute/episodic: 75% of the population, 20% of the cost

Intensive outpatient care
Complex case management
Care coordination
Population management
Decision support
Disease management
Acute time-limited intervention
Wellness and lifestyle coaching

End of life care
ER visits
High variability
Over-utilization
Poor compliance
Re-hospitalization
Complications
Social determinants
Focus on Wasted Care, Not Necessary Care

34% of every dollar spent on health care in the US is wasted*

Most waste is provider-driven, not patient-driven

Not the right care (14%)
- Not evidence-based, harmful, preventive care/screening not delivered

Uncoordinated care (4%)
- Readmissions, complications, loss of function, etc.

Overtreatment (21%)
- Motivated by something other than optimal outcome for patients

Pricing failures (14%)
- Imperfect market allows monopolistic pricing

Administrative complexity (27%)

Fraud (19%)

Measurement-Based BH Practice

Estimated: one third of patients with a BH condition receive **NO** care; one third, suboptimal care; most BH care is delivered by providers who are not BH practitioners

There are differences between research and community practice:
- Research settings, 63% respond to antidepressant medication, **65% to therapy (~12 sessions)**
- Real world, 30% to antidepressants, 20% to therapy, **3 session average***

Use of measurement tools is **not** part of routine BH practice

Patients administered rating scales are more engaged, self-aware and communicative

Aggregated data for a group can be used for quality improvement activities internally, and for negotiation of P-4-P with payers

Katzelnick D et al, Psych Services 2011; 62:929-935
## Pricing Failures

<table>
<thead>
<tr>
<th>Category</th>
<th>Model Name</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Health Management Models</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountable Care Arrangements</td>
<td>Member focused and physician driven • Risk sharing, data driven, connected</td>
<td></td>
</tr>
<tr>
<td>Patient Centered Medical Home</td>
<td>Member focused and physician driven • Rewarded for cost and quality</td>
<td></td>
</tr>
<tr>
<td><strong>Value Based Payment Models</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Cost/quality performance • Rewards hospitals, providers for exceeding metrics</td>
<td></td>
</tr>
<tr>
<td>Global Payments</td>
<td>Risk adjusted budget for the system to manage a condition • Outcomes measures</td>
<td></td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>Fixed amount for set of services for one episode of care • Focus on coordination</td>
<td></td>
</tr>
<tr>
<td><strong>Volume Based Payment Models</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee for Service</td>
<td>Rewards productivity • Inherently disincentivizes focus on cost and quality</td>
<td></td>
</tr>
</tbody>
</table>

Aetna Inc.
Uncoordinated Care

- Surrounding clinicians with data, protocols and tools supports **culture shift**, requires investments in **IT infrastructure**
- **Facilitating coordination** allows clinicians to identify and manage high-risk patients, reducing ER visits and admissions.
- **Team-based care**: combinations of providers: physician works with LCSWs, Psychologists, Nurse Practitioners, and with peer counsellors.
- Management structure headed by administrators and clinicians, constantly **measuring and improving**, responding to data
Behavioral Health Integration

Behavioral Health Integration with Primary Care Practices:
• Enhances access and continuity of care
• Increases communication and coordination of care
• Potentially reduces mental health costs and utilization
• Increases capacity of health care systems
• Improves patient experience and compliance
• Reduces stigma and affords anonymity.

BH Initial Role: keeping the human perspective, participation in family meetings, emotional functionality, physician coaching.

Medical practice resistance: limited interest or support for preventing the next generation of super-utilizers

System Barriers: CPT codes, double copayments, need for innovative reimbursement models, data/EHR sharing (single chart), methodologies for measuring impact on functioning and cost, development of data on benefits of various models

It is clinically effective and cost effective to integrate behavioral health clinicians within primary medical care
# Basic Approach for the ACO

## Out of Network Utilization

| “Boutique” programs, promoting recovery services in a luxury setting. No steerage mechanism set up to direct patients towards appropriate settings | Starts with a commitment to linking patients and care managers to direct patients within the system, local participating providers |

## Emergency Room

| About 12.5% of ER visits across all payers are due to mental health and/or substance abuse treatment needs. Seen in BH high cost/high risk population indicating a lack of access to appropriate settings for BH services | Instant access directly reduces utilization outside the system and avoidable ER and inpatient admissions. Care managers manage high-risk patients, refer to BH services, use urgent care settings in place of ER |

## Medical and Behavioral Health Comorbidity

| BH comorbidities are typically over-represented in highly complex medical conditions and are associated with ER visits, over-utilization, high care variation and poor compliance. | Comprehensive screening for BH comorbidities in those medical conditions where there is a high likelihood of impactable diagnoses may allow targeted and evidence-based interventions. |
Initial Steps for the BH Practitioner

- Measure and Track (data, outcomes)
- Adjunctive Use of e-Therapies
- Meaningful Use of an Electronic Health Record

Goal: Cost, Quality, Patient Experience

- Collaborate, Coordinate, Case Manage
- Share Best Practices, Incorporate Protocols
- Continuously Improve and Report

Goal: Get Organized!

Aetna Inc.
Key Questions about Innovations

How does the innovation contribute to the “Triple Aim”?
• Lower cost
• Higher quality
• Improved patient experience

Who wants, needs, or will actually use the innovation?
• Patient
• Provider/system/organization

How is the innovation paid for?
• Traditional Benefit Design:
  ➢ Diagnosis-driven
  ➢ Coded procedures
  ➢ Eligible providers and services
• Innovation in Reimbursement:
  ➢ Value-based, not volume-based
  ➢ Focus on results
  ➢ Shared risk