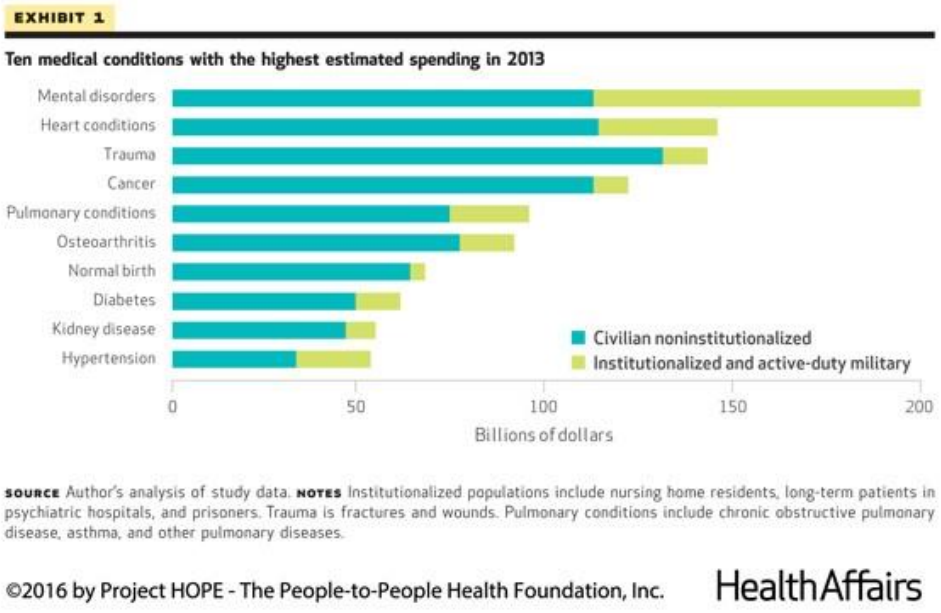
REDESIGNING BEHAVIORAL HEALTHCARE DELIVERY IN THE FACE OF OBSTACLES- IMPROVING OUTCOMES WHILE REDUCING TOTAL COST.- by David Newton



THE SCOPE OF THE PROBLEM: In 2013, it is estimated that Americans spent over $200 Billion treating Mental Health conditions, more than on any other medical condition including heart conditions, trauma, cancer and diabetes. (1) This does not include an additional $193.2 billion in lost earnings per year caused by those with serious mental illness (2). Approximately 1 in 5 adults in the US experiences mental illness in a given year (3), and approximately 1 in 25 adults in the US experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities (4). Behavioral health disorders are the leading cause of disability in the US and Canada (7) Individuals living with serious mental illness face an increased risk of having medical conditions (5), and adults living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions (6).

IT IS AN INTERNATIONAL PROBLEM: The problem is not just related to the United States. According to the World Health Organization, depression is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease. More than 350 million people are estimated to suffer from depression worldwide and as the WHO clearly and properly states, "Especially when long lasting and with moderate or severe intensity, depression may become a serious health condition. It can cause the affected person to suffer greatly and function poorly at work, at school and in the family…" (9)

MENTAL AND MEDICAL CO-MORBITIES: The connections, both medically and financially, between "mental" illness and "medical" illnesses are well established. Logically, people with mental illness are more likely to have additional medical complications, and people with medical illnesses are more likely to have mental health complications. According to the National Council for Behavioral Health, medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be 2-3 times as high as those who don't have the MH/SUD conditions. The additional healthcare costs incurred by people with behavioral comorbidities were estimated to be $293 billion in 2012 across commercially insured, Medicaid and Medicare beneficiaries in the United States. (8) In a study examining 150,000 Medicaid claims for beneficiaries in six states, authors determined that people with substance abuse disorders had significantly higher expenditures for health problems compared to others. (15).

AGAIN, THIS IS INTERNATIONAL: As the Canadian Mental Health Association clearly states in its 2008 report titled, "The Relationship between Mental Health, Mental Illness and Chronic Physical Conditions", "Mental health and physical health are fundamentally linked". People living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical conditions. Conversely, people living with chronic physical health conditions experience depression and anxiety at twice the rate of the general population. Co-existing mental and physical conditions can diminish quality of life and lead to longer illness duration and worse health outcomes". (16). Diabetes rates are significantly higher

among people with mental illness, obesity rates are up to 3.5 times higher in people with mental illness in comparison to the general population, people with mental illnesses often experience high blood pressure and elevated levels of stress hormones and adrenaline which increase the heart rate, which significantly elevates the risk of heart disease. In Canada, women with depression are 80% more likely to experience heart disease than women without depression. Similarly, people with mental illness have up to three times greater likelihood of having a stroke. (17) The relative risk of people with a mental illness developing specified chronic physical conditions is as follows: Diabetes: 1.6 for people with depression; Heart Disease: 1.6 for people with depression; Stroke: 3.1 for people with depression. Conversely, there are significantly elevated risks of depression among people with heart disease, elevated rates of anxiety and depression among people living with chronic respiratory diseases and highly elevated rates of substance abuse and eating disorders among people with a history of trauma. (all Canadian article and facts we know to be true)

INTUITION AND MORE CONNECTIONS BETWEEN MENTAL AND MEDICAL: We know that a person suffering from depression or anxiety is less likely to routinely go to their annual primary care doc visits. We know that a person with bulimia nervosa is causing massive damage to their GI system. We know that a person suffering with alcoholism is causing massive damage to their liver. We know that tobacco smoke causes cancer of the mouth, throat, larynx, blood, lungs, stomach, pancreas, kidney, bladder, and cervix. We know that injection of drugs such as heroin, cocaine, and methamphetamine currently accounts for about 12 percent of new AIDS cases. (18) And we know that people suffering from anorexia nervosa are at increased risk of the following medical comorbidities: Thinning of the bones (osteopenia or osteoporosis), mild anemia and muscle wasting and weakness, brittle hair and nails, severe constipation, low blood pressure, slowed breathing and pulse, damage to the structure and function of the heart, brain damage and multi organ failure.

SO MUCH GOES UNTREATED: Yet as the WHO also notes, although there are known effective treatments for depression, “fewer than half of those affected in the world receive such treatments”. The

National Council for Behavioral Health notes that more than one in three adults with serious impairment received no mental health treatment during the past year, with less than one third of adults with mental health disorders who do get treatment and receive care considered to be minimally adequate. (10) According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3 percent of persons aged 12 or older). Of these, only 2.6 million—11.2 percent of those who needed treatment—received it at a specialty facility. (11)

LACK OF PARITY: Despite the growing costs of mental health care, these illnesses do not get the same level of research funding as heart disease, diabetes or cancer. The National Institute of Health estimates it will spend $396 million on serious mental illness in 2016, whereas heart disease, cancer and diabetes will receive $1.3, $5.7 and $1 billion in funding respectively. Anxiety disorders and depression, the most common mental health conditions, will receive much less- $163 and $406 million (19)! Further and as noted above, despite the enormity of the problem less than half (41%) of adults in the US with a mental health condition received mental health services in the past year.

PROPER TREATMENT WORKS, AND IT'S "WORTH IT": The case for duly treating mental health as vigorously as we treat "medical" health could not be any more substantiated. Proper treatment saves lives and it can save billions in healthcare dollars. Researchers have noted that, "the vast majority of individuals with mental illness who receive appropriate treatment improve….. For major depression, panic disorder and obsessive compulsive disorder rates (of improvement) are about 70%. This is comparable to rates of improvement for people who suffer from physical disorders, including diabetes and asthma at 70-80%, cardiovascular disease from 60-70% and heart disease at 41-52% (12). The National Institute on Drug Abuse estimates that every dollar invested in addiction treatment programs yields a return of between $4 and 7$ in reduced drug related crime, criminal justice costs and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1! (13). The

US Department of Health and Human Services estimates that for every $100,000 invested in treatment for substance abuse (measured in California, New York and Washington), there are savings of $484,000 in health care costs and $700,000 of crime costs were shown to be avoided. (14) In a comparison of medical expenses of Medicaid clients who received treatment, the following savings were noted (measured in Washington): $170.00/month for patients receiving inpatient; $215/month for those in outpatient treatment, and $230/month for those receiving medication assisted therapy (specifically methadone). In California treated patients have been shown to reduce ER visits by 39%, hospital stays by 35% and total medical costs by 26% (14).

Just by integrating medical and behavioral services, The National Council for Behavioral Health estimates that between $26- $48 billion can potentially be saved!

If we are to make real progress, we need to increase access to care and we need to address the current state of fragmentation both between mental and medical health as well as within mental health itself. We must adapt universally accepted outcome measurements (leading to greater cost transparency) that can be used by providers, patients and payers alike to make informed decisions and to hold one another accountable for their part of treatment and recovery. If we can make headway in these three key areas, more people will seek and receive treatment for their mental health issues, patients will become more healthy both "mentally" and "physically", and **total** healthcare dollars will be saved as a result.

BARRIERS TO PROGRESS: STIGMA AND SHAME: Many still living in the dark ages believe addiction is a choice. At SCH we believe addiction is a disease, just like diabetes or cancer. We know from science that an addicted person's brain has a disrupted choice mechanism. As The National Institute on Drug Abuse says, "However much we may wish that a person's choices were free in all instances, it is simply a fact that an addicted person's failures in the realm of choice are the product of a brain that has become greatly compromised—it is readily apparent when we scan their brains…" The whole concept of anonymity in Alcoholics Anonymous or any of the other twelve step programs is telling. When people go

to physical rehab for a broken and healing bone, is there an oath of secrecy associated with the patient's visit? There is nothing to be ashamed of by attending a recovery meeting for addiction, and yet this persists. At (SCH), we support the de-stigmatization of these diseases that has occurred over the years. We teach our patients that what they are suffering from is a disease, just like diabetes or cancer. We don't believe people choose to ruin their lives and families when they become addicted to opiates. The activity in the brain that occurs when an addict is sick is nothing she can control. We are working with EAP programs and Human Resource Executives at major companies trying to educate them on how to help their employees feel more comfortable asking for help. We learned recently and were abhorred to hear that one EAP program actually tells first time callers that their calls are being recorded!!!! As more and more people begin to understand that these are real medical diseases that manifest themselves similarly to other disorders around which the patient has little control, more people will seek help earlier and recover quicker, which will also result in diminished disease burden and need for long-term health resources. Most importantly, fewer people will die because they were ashamed to ask for help.

BARRIERS TO PROGRESS, LACK OF PARITY: Why has mental health been separated or carved out from mainstream health care delivery? Why do mental health providers spend so much of their time arguing with payers over authorization and medical necessity of their services when this rarely happens with medical conditions? Why is there a special (and additional) deductible for "mental health" with many insurers? Despite the federal "parity" law enacted in 2010 (Mental Health Parity and the Patient Protection and Affordable Care Act of 2010), "discrimination still exists toward mental health and substance use conditions", according to NAMI Executive Director Mary Gilberti. She goes on to say in an April 1, 2015 report published by NAMI, "Progress is being made, but there is still a long road ahead. The act contains a number of provisions that generally combine to extend the reach of existing federal mental health parity requirements, and is a response to the disparity in insurance coverage between mental illness and other physical illnesses. According to the Congressional Research Service report dated 12/28/2011, "…parity generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits". (31) Yet in

the NAMI report dated April, 2015, NAMI identifies areas, "where insurance companies need to improve and greater scrutiny is needed." This report specifically cites some following conclusions: 1) a lack of mental health providers is a serious problem in health insurance networks. 2) Nearly a third of survey respondents reported insurance company denials of authorization for mental health and substance abuse care. For ACA plans, denials were nearly twice the rate for other medical care. 3) High co-pays, deductible and co-insurance rates create further barriers to treatment and 4) there is a serious lack of information about mental health coverage to enable consumers to make informed decisions in choosing care". (30) At SCH we make the case every day with patients, their families, their payers and their employers that mental health benefits should at the very least be treated equally with other physical illnesses. We do this as we have utilization review calls with payers, we do this when talking with EAP's and Human Resource and Benefits groups at major employers in the Chicago area and we blog about it on our website, on twitter, on LinkedIn and at every chance we can. We believe the cost benefit analysis speaks for itself; Investing in mental health treatment saves lives and it saves dollars. Further, discriminating against those with mental illness by not reimbursing or covering it like other illnesses perpetuates the myth that addiction, for instance, is a choice which feeds in to the shame stigma and ultimately gets in the way of treating these illnesses as illnesses just as we do with other illnesses- early, often and as aggressively as we can because we know our outcomes are better when we do this and because it is the right thing to do.

BARRIERS TO PROGRESS, FRAGMENTATION BETWEEN MENTAL AND MEDICAL. In the United States health care system, there is massive fragmentation between medical and mental health provision of care. Most payers and providers alike behave as if medical health and mental health have little to do with one another. As noted above, many studies have substantiated the costly impact of untreated or under treated mental health conditions (for example depression) on a person's medical health. Despite this, many physicians know little to nothing about diagnosing mental illness and they know even less about addiction. Training of mental health is minimal at many medical schools and it is even less with other specialties such as Dentists. Intuitively we know that a patient with untreated or

inappropriately treated mental illness, whether that be depression, bipolar disorder, addiction, PTSD, or an eating disorder, is ill-equipped to take care of herself medically. People with active addiction or depression are less likely to see a doctor for an annual physical exam where they may receive screening for a preventable illness. As noted by the Canadian Mental health Association's report of 2008, people with serious mental illness who have access to primary health care are less likely to receive preventive health checks. They also have decreased access to specialist care and lower rates of surgical treatments following diagnosis of a chronic physical condition. Mental illness, at its root, affects a person's thinking, planning, and motivation to care for self and warps their beliefs about what they deserve and are capable of accomplishing.

Another example tells the story.... A 45 year old female with cocaine dependence, BED, bipolar disorder, opioid dependence and history of developmental trauma presents. She came to us seeking a psychiatrist for buprenorphine. Many addiction psychiatrists would likely see her for utox and sub Oxone med management monthly. They may see her for 15 minutes every other week, they won't coordinate care with her primary care doc or any of her other docs and as a result they may prescribe her medicine that might very well be harmful to her given her overall health history.

At SCH, she receives a thorough bio-psycho-social-spiritual evaluation. Her former prescriber is contacted for information sharing. It turns out she has no PCP, has never had a mammogram, she does not get pap smears because she is ashamed of her body. She sees a GI doc for reflux. At SCH she gets a PCP who works with the psychiatrist to manage this patient long-term both medically and psychiatric ally. If medical recommendations are not being followed, this becomes a therapeutic issue addressed by the psychiatric team in weekly individual session and group sessions. Further, at SCH mental health care is integrated. The whole patient is addressed, not parsed out by disease treated sequentially or in parallel using fundamentally different modalities. We even go so far as to regularly check the new prescription monitoring program where we are able to see what medications our patients may be getting from other doctors. We had a case recently where a woman who suffers from cocaine addiction was being

prescribed Adderall by one of her other (ignorant) MD's. We learned of this by using the PMS, we confronted the patient and we coordinated her care so as to ensure this wouldn't continue to happen.

BARRIERS TO PROGRESS, SILOS WITHIN BEHAVIORAL HEALTHCARE: The system today is incredibly siloed and often results in a game of "whack a mole" as one "primary" symptom is addressed yet because the underlying cause was not or the "secondary" diagnosis was not made nor addressed, another symptom pops up and the patient relapses in to a similar yet on the surface different type of addiction. Many of the most well esteemed hospital systems and providers in the country have separate tracks, for instance, for eating disorders, substance abuse disorder and trauma. This, despite the following according to NEDA: Research suggests that nearly 50% of individuals with an eating disorder (ED) are also abusing drugs and/or alcohol, a rate 5 times greater than what is seen in the general population. The co-occurrence of these disorders affects both men and women with up to 57% of males with BED experiencing lifelong substance abuse problems. Eating disorders and substance abuse are independently correlated with higher than expected rates of death both from medical complications as well as suicide. An example- A patient presents with what is diagnosed as binge eating disorder and they get put on the "eating disorder" track where hopefully they learn to control (and reduce) their intake of food to a moderate amount and then they are discharged. On the other end of the hall are patients who present with, say, an addiction to drugs. These patients will hopefully learn to eliminate their consumption of drugs through maybe medication assisted therapy, behavior therapy, family therapy and other forms of therapy. Both populations are suffering from addictive behaviors yet they are placed on separate tracks. What gets missed in this approach is the many commonalities each of these populations share to include the fact that some form of trauma or depression or other mood disorder is likely at the root of the primary symptom. Thus, when the food addict is able to manage their food intake and yet the underlying cause was never addressed nor did they learn the tools needed to fight imminent future urges for other substances, the next major stressor in their life could lead them to now find themselves addicted to alcohol or some other substance. At SCH we do not put patients on separate tracks, as we use an integrated approach where we are not only integrating medical with behavioral but we are assessing and

integrating our patients overall mental health. We seek to treat the symptom and its underlying cause, giving our patients the tools they need to be free and healthy from all addiction. Not all providers are capable of seeing the patient in this light and the literature supports the fact that co-occurring disorders can be difficult to diagnose due to the complexity of symptoms…. And inadequate provider training or screening, an overlap of symptoms, or other health issues that need to be addressed first. Hiring the right therapists is critical to maintaining this integrated approach, and then ensuring we do not fall in to the easy trap of segmentation, treating the one symptom without regard for others that may be going on at the same time- which all too often leads to relapse. Supported by a 2014 SAMHSA report, we know that people with co-occurring disorders are best served through integrated treatment. This often leads to better health outcomes and lower healthcare costs. (32)

Yet this same SAMHSA article sheds light on an inherent major problem that is not only a major barrier to treatment but one that also forces some providers to game the system in order to treat their patients. The report states the following: *People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder*. According to the National Institute on Drug Abuse, drug addiction is a mental illness. An addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviors that override the ability to control impulses despite the consequences are similar to hallmarks of other mental illnesses. Insurance companies do the same. When applying for in network status, SCH was asked by all whether we provide "mental health" OR "substance abuse treatment" Our answer- they are the same and so we provide both. From a patients perspective this separation can prove fatal and sometimes leads to good intentioned providers gaming the system in order to get their patients the treatment they need. For example, not all patients have residential coverage for all of their mental health conditions, despite ACA and Parity. Commonly, a patient with an acute substance use disorder as well as an eating disorder will have RTC (residential treatment) benefit for mental health (ED) but not substance use disorder, or vice versa. It is possible then that this patient would not receive authorization for treatment of their substance

use disorder because somehow the payer sees substance as different from mental health, and visa versa. For people who do have benefits for both MH and SUD, most often if they have co-occuring disorders only the identified "primary" disorder is authorized for treatment. At SCH we are being very transparent with payers that our integrated approach may lead to us not being able to provide them with a "primary" diagnosis particularly when the patient presents with co-occurring diagnosis. From our perspective, it does not matter what the primary is and we do not and will not just treat the primary. We will treat the person. When one of our clinicians was asked in an interview what they would treat first, a substance abuse diagnosis or a depression diagnosis, the answer was literally, "it doesn't matter…" We will of course treat any acute aspect first and foremost but after that we are treating the whole person, meeting them where they are at and getting to the root cause(s), or as close as possible. We won't and don't game the system like some providers do and it is too early to tell how payers will respond to our steadfast approach to integrated treatment.

BARRIERS TO PROGRESS, REACTIVE (and more fragmented) CARE. The Current models of delivery of mental health are reactive instead of preventative. Care is episodic and fragmented, rather than a longitudinal provision of care for people with chronic illnesses (many of whom achieve full remission...AND do best with ongoing preventative care in an outpatient setting). One example illustrates the issue- The person who has been to rehab 5 times for polysubstance dependence. They have been sober for 4 years, they are attending AA, and they now need a dental surgery, or an appendectomy. They end up being prescribed post-op narcotic pain meds prescribed by a provider who has had little to no addiction training, the sober patient is not fully aware of the support warranted to take these meds as they are prescribed and decides she can do it on her own. After all she's been sober 4 years. That said, she takes the medication without any support and relapses once her prescription runs out. At SCH as that patient's outpatient provider, or monthly addiction psychiatrist, we would collaborate with the surgical team and patient's support system to facilitate the following plan: the patient never touches the prescription, her designated loved one fills it, and the loved one hands out the med as prescribed to patient in recovery from addiction. She gets an appointment with her long term addiction treatment professional (preventative

care) the day after her pain med stops. The relapse is prevented, thousands of healthcare dollars are saved and most importantly potentially a life is saved.

BARRIERS TO PROGRESS, NO COST TRANSPARENCY

As we have noted above, payers are simply not looking at the medical co morbidity of these behavioral illnesses and therefore they don't have a real grasp of actual costs. We met with one company recently with over 10,000 employees nationwide and their data shows that they "only" spend" about $1 million on substance abuse issues. Clearly that number is not accurate and although we have not yet had a chance to parse through that data and identify what they are counting and what they are not counting, it is clear they aren't counting indirect costs such as absenteeism, lost productivity or the cost to replace workers who either get injured or leave the job because of their problems. They are also not counting the medical co-morbidity, which the literature and data support are significant. At SCH we are teaching payers and employers alike that it is far less expensive to treat a patient on an ongoing outpatient basis for their behavioral problem (i.e. Symptomatic Nicotine addiction) than to ultimately see them get something like lung cancer and have extensive surgery. We are also offering to parse through data for employers and payers in order to help them understand the true costs of some of these behavioral illnesses. Many of them admit they know their numbers are not accurate and yet sometimes because the silos for medical and mental health are so strong or sometimes because they just don't have the interest or the resources, they won't allow us to do the work for them. Yet we believe this is an important piece of our mission. Once we can show the investment is worth it, critical mass will begin to move- especially with self-insured companies who would like nothing more than to see their employees more healthy AND reduce their TOTAL healthcare spend in the process!

The other critical piece of transparency and the lack thereof in this space involves the lack of universally accepted outcome measurements. Many providers measure no data. Many measure what they are good at it and through their own biases and unsophisticated analyses, report what looks good and conveniently leave out what may not look so good. Although established and highly regarded groups like Michael

Porter's ICHOM have a standard set (of outcome measurements) for depression, there is currently nothing (that we are aware of) established for substance use disorder or eating disorders. There are some common measurements but nothing standardized across the industry used by most of not all providers. This makes it impossible for patients to compare providers when trying to make an informed decision on where to seek treatment and it makes it impossible for payers to negotiate fairly between providers based on the value they provide their patients and their patients families. At SCH we are working with leaders in the industry to establish outcome measurements that we feel accurately reflect measurements that matter to our patients and to us as their providers. We are tracking those outcomes using an electronic health records management system and we intend to share the data with our patients and their payers as we go. Further, we intend to publish what we are measuring, why and how we are doing it with the hope that others will follow. Without standardized and universally accepted outcome measurements, it will be impossible to move from a fee for service reimbursement model to a model based on the value we provide our patients. As a new entrant eager to be reimbursed for our value rather than our volume, this initiative is an integral part of our mission.

BARRIERS TO PROGRESS- MOVING TOWARD VALUE IS NOT EASY IN THIS SPACE!

In order to move to a reimbursement model where we are rewarded for the value we create for our patients and their families we need to do share in some of the risk for our portion of the provision of care over which we agree to be responsible. This requires, amongst other things, that we can risk adjust in to three of four buckers as patients present and it also requires a definition of “the episode of care”. Unlike those who may be getting a knee replacement, these are not easy tasks with our population. Further, we ideally create not only care teams that include various medical, behavioral, therapeutic specialists- all designed around the conditions of our patients- but we ideally bundle our payment so that we are all fully aligned as we treat our patients. This is particularly difficult in mental health given that many therapists and psychiatrists themselves want nothing to do with insurance and in many cases don’t feel, given current state of fragmentation and lack of coordinated care, that they could afford to be help responsible

for say what the patients primary care doc does (or does not do) in the provision of care over "the episode". At SCH we understand the challenge is significant. Yet we are convinced that the current fee for service model is not only broken but it is unsustainable and truly does not work in the best interest of our patients or our families. We are actively and diligently working on piloting different models of how to bring the right care team together and have a reimbursement model that works. We feel strongly that for a patient suffering from a mental illness that it should be the psychiatrist who could be the gate keeper of sorts and leader of the team- who is responsible for care coordination and who creates the care team and pays all other providers based on the value the team delivers. By no means do we claim to have this ironed out, yet we are moving the conversations we have and contract discussions we have in this direction to the extent we can.

CONCLUSION: The data supports the inherent value of an integrated treatment model where medical and (sometimes multiple) behavioral issues are treated both equally and with regard for one another. The data shows that that there is a tremendous opportunity to a save a tremendous amount of total healthcare dollars by investing in effective and integrated treatment. The data shows that this is an international problem of epic proportion with depression leading as the most costly illness on the planet. Despite the multiple barriers getting in the way, we know we can and will do better by chipping away at the barriers one by one. At SCH we are providing care by designing our care teams around our patient's needs and conditions. We are measuring outcomes and we know what our cost drivers are. By modeling to the industry that this treatment model is in the best interest of our patients, their families and their payers, we hope to make a difference and move the needle toward better care at a lower total cost. In as much as a relatively small, independent and currently self-funded new entrant such as SCH might not have the data nor the volume we need to move as quickly as we might like, we know we are doing our job so long as we remain true to our guiding principles and continue to break down these barriers every day we come to work. It is what our patients deserve. It is what we all deserve.