ACHIEVING INTEGRATED CARE IN NORTH CAROLINA

An ICARE Policy Brief in Support of Governor Perdue's Behavioral Health Agenda

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Governor Perdue's Agenda

Governor Perdue has been very clear that one of her goals is to delivery quality health care to all North Carolinians, and that must include integrated behavioral health care. As she stated in her position paper:

> *"My background in health care tells me that it makes no sense to separate mental from physical care. The best research confirms that many patients have mixed mental and physical health issues."*

As Governor, she would like to

> *"establish the national model for an integrated approach to behavioral and primary health services for patients with mental health, developmental disability and substance abuse problems."*

Finally, Governor Perdue indicated that an essential component of an effective, reformed mental health system is the establishment of a *"medical home"* for all those served by the mental health system. She cited the award winning example of Community Care of North Carolina, *"which has developed a very cost effective and quality driven model of statewide case management through health care community networks."*

After the election, Governor Perdue convened a Transition Advisory Group Session on Mental Health, Developmental Disabilities and Substance Abuse Services. One of the six priorities identified by the Department of Health and Human Services (DHHS) and the Dvision of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is to:

> *"Integrate behavioral health care into the primary care setting and improve collaboration with primary health care providers."*

The ICARE Project

ICARE (**I**ntegrated, **C**ollaborative, **A**ccessible, **R**espectful, and **E**vidence-based) was designed to improve patient outcomes by:

- Increasing collaboration and communication between primary care and MH/DD/SAS providers.

- Increasing the capacity of both primary care practices to provide appropriate, evidence-based behavioral health services and of specialty MH/DD/SAS providers to screen and refer for physical illness.

The ICARE Advisory Board membership reflects broad support for the project from governmental agencies, primary care providers, psychiatric professionals, postgraduate, professional and consumer advocacy organizations (see Appendix I for a complete list of Board members).

ICARE programs have been implemented in the context of increasing challenges in the delivery of NC behavioral health services, especially to individuals suffering from more serious disorders and/or who are uninsured.

In a very short period of time, and with the support of Office of Rual Health and Community Care and funding from the Duke Endowment and the Kate B. Reynolds foundations, ICARE has accomplished a great deal, in effect becoming a Center of Excellence for Integrated Care (see Appendix II for the most recent progress report), including:

- the development of a very successful website (www.icarenc.org)
- the implementation of many model programs (with important lessons learned from each).
- the provision of innumerable workshops and continuing education activities.
- becoming a central statewide clearinghouse for innovations in integrated care.
- establishing a national reputation for being a pioneer in integrated care.
- and central to this Policy Brief, the identification of key policy and process issues which must be addressed for the Governor's objectives for integrated care to be fully realized in North Carolina.

<u>The Critical Need for Addressing Policy Barriers to Full, Statewide Implementation of Integrated Care</u>

- Most patients suffering from depression, anxiety, substance abuse and ADHD are treated only by their primary care physician.
- Referrals by PCPs to specialists are often, for many reasons, difficult.
- Most patients with depression, anxiety and substance abuse disorders are not treated at all; health care providers do not routinely screen for these conditions despite their prevalence.
- Patients with chronic medical conditions (e.g. asthma, diabetes) and those with behavioral risk factors (e.g. obesity and smoking) are more likely to suffer from comorbid behavioral health disorders.
- Patients with severe mental illnesses have significantly lower life expectancy than the general population, disproportionately suffer from chronic medical conditions and are at greater risk because of both lifestyle factors (e.g. obesity and smoking) and difficulties accessing health care.

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- When implemented in a manner consistent with evidence-based practice, integrated care helps patients be more productive at work and in school, improves individual physical and psychological health, and supports family stability.
- There is increasing evidence that integrated care reduces, or at least does not increase, overall health care costs. This is particularly true for those patients who present with chronic medical conditions. Integrated care is a key component of a high performance health system, one which delivers efficient, accessible, and outcome-focused care.

An Action Agenda for Statewide Implementation of Integrated Care

ICARE has centered its efforts on supporting integrated care across all payers and all types of public and private practice environments. Indeed, the most cost-effective improvements in healthcare occur when the efforts of the public and private sectors are closely coordinated. However, this policy brief is addressed to leadership in state government and therefore does not include many of ICARE's recommendations regarding private payers.

1. DHHS Leadership Challenge:

   One of the most significant impediments to resolving a variety of structural, legal, fiscal and procedural barriers to integrated care has been the absence of a high level intergovernmental task group at the DHHS level charged with addressing those barriers. While there are many talented individuals in DHHS Divisions who are committed to integrated care, it is often extremely challenging to focus the energy and resources to move issues forward. A task group, accountable to the Secretary, should be charged with approaching integrated care as a critical public health issue which affects well over 1,000,000 North Carolinians. The ICARE Project could both be the linkage to a broader array of public and private stakeholders and provide staff and research support for the Task Force. Federal and state healthcare reform (including providing health care to the uninsured) will present major policy opportunities for Governor Perdue's administration to address this important public health issue. One of the first tasks of the DHHS Task Force should be to tackle the interface between LMEs and CCNC health networks.

2. Regional Leadership Opportunities:

   Currently, there are two sets of statewide regional organizations responsible for planning and delivering health and behavioral health services for Medicaid and uninsured populations on a statewide basis: 1) regional health networks under the auspices of the Office of Rural Health and Community Care and 2) Local Management Entities who organize and regulate networks of specialty providers under the auspices of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. While these networks have begun to interact with each other, particularly in those areas with pilot projects supported by ICARE, there is no

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statewide plan or even a memorandum of agreement about how regional health networks and the LMEs should address the needs of the populations they jointly serve. Yet both networks engage in quality improvement activities; both deliver case management services directly or indirectly; both promulgate evidence-based practices; both are charged with serving Medicaid eligible disabled individuals.

3. Workforce Issues:

   The ICARE Project, with the collaboration of the AHEC system and the professional associations, has made significant progress in providing training opportunities for primary care providers and behavioral health specialists. However, to meet the current need, much more must be done to support and promote primary care integration training in graduate, postgraduate and continuing education programs.

   - More primary care providers must be trained to screen and treat common behavioral health issues, to work in integrated settings with behavioral health specialists, to address the special needs of more disabled populations, and to collaborate with the specialty mental health system.
   - More behavioral health specialists must be trained to work in primary care settings through both continuing education programs and specialized curricula in graduate training programs.
   - More psychiatrists and psychiatric residents must be trained to provide consultation and telepsychiatry services to primary care settings.
   - More physician extenders must be trained to work in integrated care sites.
   - MH/DD/SA provider organizations must be trained to screen and monitor the health status of their consumers and collaborate with health providers.

   The DHHS Task Group, working collaboratively with postgraduate educational organizations, should set specific objectives regarding the number of professionals to be trained. Highly effective structures already exist that can execute a DHHS plan (e.g. University graduate programs, AHEC, postgraduate certification and continuing education programs, ICARE), but there is a need for direction which is guided by North Carolina's behavioral health priorities.

4. Reimbursement Barriers:

   While the pilot sites have learned much about reimbursement support for integrated care, sustainability has remained a challenge. A reimbursement system should support interventions which are most likely to achieve positive outcomes for patients at a reasonable cost. While there has been some progress (North Carolina's parity legislation is a notable example), barriers remain.

   - Screening: While primary care providers deliver over half of mental health treatment in this country, they fail to identify as much as half of the mental

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health problems experienced by their patients. The incidence of behavioral health problems is particularly high among individuals with chronic medical conditions. Thus, it is essential that there is reimbursement support for routine screening of patients for anxiety, depression and substance abuse. National billing codes already exist for screening, but many payers do not reimburse for this activity.

- Consultation between psychiatrists and primary care providers: Payers should reimburse both parties for the cost of consultation between a primary care provider and a psychiatrist around a specific patient. The expected savings and improvements in care will more than offset the additional cost.
- Telepsychiatry: Given the shortage of psychiatrists, telepsychiatry is often a cost-effective way to deliver psychiatric services to primary care entities in rural areas. The full cost of telepsychiatry to both parties should be reimbursed and consideration should be given to regional telepsychiatry services, possibly linked with regional AHECs and the medical schools.
- Telephone follow-up: Following up patient status and medication adherence is best practice when primary care professionals treat depression and other mental health issues. Evidence-based protocols exist for how frequently follow-up should be done. Offices which follow the protocols should be appropriately reimbursed.
- Behavioral inteventions to prevent or mitigate chronic medical conditions: Behavioral health CPT codes exist which encourage primary care providers to address behavioral issues related to such conditions as obesity and tobacco use and to help patients cope with chronic medical conditions. Use of these codes is linked to the underlying health risk or medical condition and does not require a psychiatric diagnosis. These codes should be reimbursed by all payers.
- Diagnosis: Some payers reimburse primary care providers at reduced rates when they treat psychiatric diagnoses. This reimbursement differential is unjustified.

5. Promoting Quality Care:

An effective quality improvement process is central to the successful implementation of integrated care. The CCNC model of quality improvement should be extended to behavioral health services. In CCNC, the foundation for all quality improvement efforts is the establishment of a primary care medical home for all patients. Without a clear medical home, it would be much more difficult to assure continuity of care and successfully implement treatment protocols based on evidence-based practice. Outcome data is systematically collected and feedback is provided to the regional health networks, their constituent practices and individual

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practitioners. Protocols are modified as appropriate based on a review of outcomes and the experience of the networks.

- New protocols should be developed in priority behavioral health areas. Among those which might be considered are depression, anxiety, ADHD and substance abuse.
- A protocol should be developed for monitoring the health status of individuals with severe mental illnesses and substance use disorders. This protocol should be known to all behavioral health providers serving this population.
- DMH/DD/SAS has been promoting best practice interventions for individuals with severe behavioral disabilities. Primary care providers should be made aware of these best practices, so that they have a better understanding of what specialized behavioral services might be available to their patients.
- The North Carolina Healthcare Quality Alliance was established to align quality measures across payers, provide feedback on performance to practices, and “support practices throughout the quality improvement process using nationally-recognized models.” While behavioral health problems were not among the initial conditions targeted by the Alliance, DHHS should encourage the group to consider expand their focus, possibly beginning with depression.
- Finally, DHHS should determine how to ensure the establishment of a medical home for all uninsured patients served by the public mental health system.

6. Information Exchange:

Some of the most troubling barriers to integrated care are the perceived and real obstacles to sharing information between primary care providers and behavioral health specialists. To some degree, failures to communicate have been the result of limited information or misinformation about who is delivering care or what each party needs from the other. ICARE pilot sites have developed communication protocols in collaboration with primary care and specialist providers that can help remedy this aspect of the problem. ICARE has also worked with the NC Medical Society to develop an approved consent form. However, there are other arenas where the DHHS Task Force can facilitate further progress.

- The Governor should consider proposing legislation that facilitates administrative and clinical information exchange. In particular, confidentiality regulations governing the disclosure of information by behavioral health providers and facilities should be modified to ease the sharing of critical information with primary care providers.

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- DMH/DD/SAS should provide guidance regarding the essential information behavioral specialists and facilities should be sending to primary care providers.
- Federal substance abuse confidentiality regulations are overly restricitve and jeopardize the health of patients they are intended to protect. DHHS should lobby to have them changed.
- DHHS should consider adopting the October, 2008 recommendations of the National Association of State Mental Health Program Directors regarding the "Measurement of Health Status for People with Serious Mental Illness."

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