AMERICAN HOSPITAL ASSOCIATION
JANUARY 2012

TRENDWATCH

Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes

One in four Americans experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition.[1] In 2009, more than 2 million discharges from community hospitals were for a primary diagnosis of mental illness or substance abuse disorder.[2,3]

The range of effective treatment options for behavioral health disorders—which encompass both mental illness and substance abuse disorders—is expanding. Research indicates that better integration of behavioral health care services into the broader health care continuum can have a positive impact on quality, costs and outcomes.

Mental illnesses are specific, diagnosable disorders. Each is characterized by intense alterations in thinking, mood and/or behavior over time. Substance abuse disorders are conditions resulting from the inappropriate use of alcohol, prescription drugs and/or illegal drugs.[4] Behavioral health disorders may also include a range of addictive behaviors, such as gambling or eating disorders, characterized by an inability to abstain from the behavior and a lack of awareness of the problem.[5]

Health reform creates new impetus and opportunity for better managing the care delivered to individuals with these conditions. Expansion of health insurance generally, along with improved coverage of behavioral health treatment under parity laws, will broaden access to needed services. At the same time, increased provider accountability will spur efforts to coordinate care across currently fragmented settings to improve the efficiency and effectiveness of care delivered to individuals with behavioral health conditions.

Many providers already are working with private payers to meet these same goals. Initiatives span value-based purchasing, accountable care organizations, patient-centered medical homes, and efforts to reduce readmissions. These initiatives will have important implications for the delivery of behavioral health care. And as the demand for behavioral health services is likely to continue to outstrip capacity, improving care integration can help to better manage this need.

Highly Prevalent, Behavioral Health Disorders Have a Significant Economic and Social Impact

Behavioral health disorders affect a substantial portion of the U.S. population. Nearly half of all Americans will develop a mental illness during their lifetime.[6] An estimated 22.5 million Americans suffered with substance abuse or dependence in 2009,[7] and 27 percent of Americans will suffer from a substance abuse disorder during their lifetimes.[8] While behavioral health disorders primarily affect adults, they also are prevalent among children. Among children, mental health conditions were the fourth most common reason for admission to the hospital in 2009.[9] Studies reveal that approximately 17 percent of Medicare beneficiaries have a mental illness.[10] An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year.[11]

The economic and social costs associated with behavioral health are significant, underscoring the importance of treating these conditions.[12] In the majority of cases, behavioral health conditions are serious enough to cause limitations in daily living and social activities.[13] For example, behavioral health conditions hinder worker productivity and raise absenteeism, resulting in reduced income

American Hospital Association

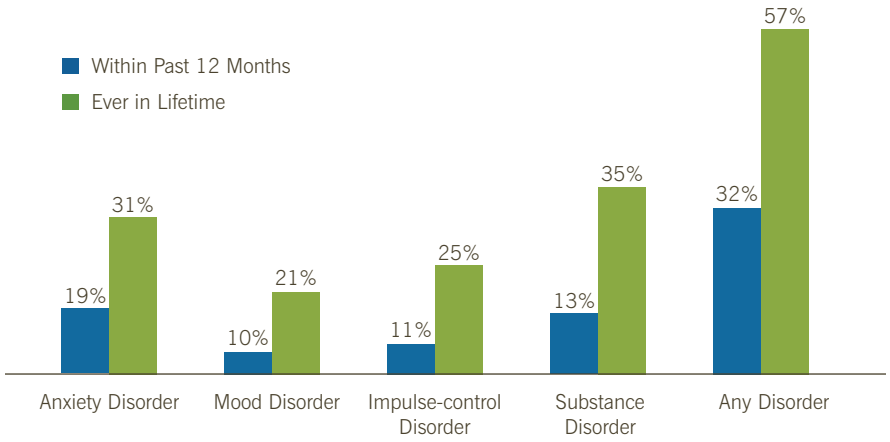
or unemployment.[14] In 2007, persons diagnosed with serious mental illness had annual earnings averaging $16,000 less than the general population.[15] Each year, approximately 217 million days of work are lost or partially lost due to productivity decline related to mental disorders, costing United States employers $21.7 billion annually.[16, 17]

Behavioral health disorders also can have a profound social impact. Individuals with behavioral health conditions are more likely to live in poverty, have a lower socioeconomic status, and lower educational attainment.[18] Lack of treatment amplifies these outcomes and increases the likelihood that individuals will end up homeless or incarcerated.[19]

These social impacts, in conjunction with treatment costs, present a significant and growing economic burden that has made mental illness one of the five most costly conditions nationwide.[20] In 2008, the U.S. spent nearly $60 billion on mental health services, up from $35 billion in 1996.[21] In contrast to general health care services, in which public and private payers account for roughly equal shares of spending, public payers account for the majority of behavioral health expenditures. In 2005, Medicaid and state and local governments accounted for 61 percent of behavioral health care expenditures, compared with 46 percent for all health services.[22]

Behavioral health conditions are prevalent among adults in the U.S.

Chart 1: Percent of U.S. Adults Meeting Diagnostic Behavioral Health Criteria, 2007



Note: Anxiety disorder includes panic disorder, agoraphobia, specific phobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, and adult separation anxiety disorder. Impulse-control disorder includes oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, and intermittent explosive disorder. Substance disorder includes alcohol abuse, drug abuse, and nicotine dependence.

Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Behavioral Health Disorders and Medical Conditions Often Co-occur, Raising the Risk of Suboptimal Outcomes

Individuals with behavioral health disorders often have co-occurring physical health conditions. In the past year, 34 million adults—17 percent of American adults—had comorbid mental health and medical conditions.[23] Mental health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other. For example, a recent study found that individuals with bipolar disorder, on average, have a greater number of medical conditions than individuals without claims for mental illness.[24] And a study of Medicaid beneficiaries in New York State determined that, among patients at high risk of hospitalization, 69 percent had a history of mental illness and 54 percent had a history of both mental illness and alcohol and substance use.[25]

Individuals with co-occurring physical and mental health conditions present many treatment challenges. A physical condition may exacerbate a mental health condition, while a mental health condition may hinder treatment for a physical ailment. Medical conditions with a significant symptom burden, such as migraine headaches, chronic bronchitis, and back pain are associated with increased incidence of major depression.[26] About one fifth of patients hospitalized for a heart attack suffer from major depression, which roughly triples their risk of dying from a future heart attack or other heart condition.[27] Depressed patients also are three times more likely than non-depressed patients to be noncompliant with treatment recommendations.[28] Moreover, individuals with mental illness more frequently have risk factors, such as smoking and obesity, which contribute to increased likelihood of chronic conditions such as stroke and diabetes.[29]

Patients with comorbid mental health and medical conditions experience higher health care costs, with much of the difference attributable to higher medical, not mental health, expenditures. One analysis found that although the presence of comorbid depression or

anxiety boosts medical and mental health care costs, more than 80 percent of the increase stems from medical spending. Monthly costs for a patient with a chronic disease and depression are $560 more than for a person with a chronic disease without depression.[30]

The presence of comorbid conditions also can lead to suboptimal patient outcomes. Research indicates that individuals with mental illness die younger than people without such diagnoses, but from the same leading causes of death as occur nationwide, such as heart disease and cancer.[31] Individuals with serious mental illness die, on average, 25 years earlier than the general population.[32] Such poor outcomes may be linked to lack of appropriate care. One study found that almost one third of patients with schizophrenia did not receive appropriate medical treatment for their diabetes, and 62 percent and 88 percent, respectively, did not receive appropriate treatment for high blood pressure and high cholesterol.[33]

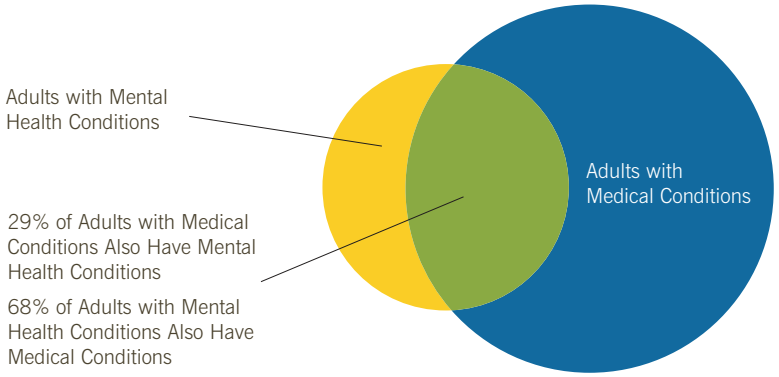
Individuals with comorbid conditions are at heightened risk of returning to the hospital after discharge. A Canadian study found that 37 percent of patients with mental illness discharged from acute care hospitals were readmitted within a period of one year, compared with only 27 percent of patients discharged without a mental illness.[34] In addition, individuals with substance use disorders are among the highest-risk populations for medical and psychiatric rehospitalizations.[35]

Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital. One study found that heart attack patients who were depressed were more likely to be readmitted in the year after discharge.[36] Another study concluded that patients with severe anxiety had a threefold risk of cardiac-related readmission, compared to those without anxiety.[37]

Among children, the risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge.[38] This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services.

Individuals with behavioral health conditions frequently have co-ocurring physical health conditions.

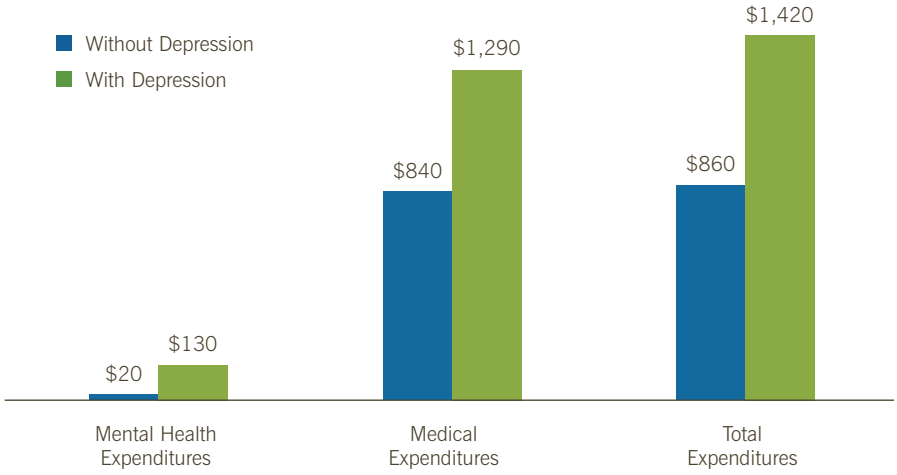
Chart 2: Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003



Source: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

The presence of a mental health disorder raises treatment costs for chronic medical conditions.

Chart 3: Monthly Health Care Expenditures for Chronic Conditions, with and without Comorbid Depression, 2005



Source: Melek, S., and Norris, D. (2008). *Chronic Conditions and Comorbid Psychological Disorders*. Cited in: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

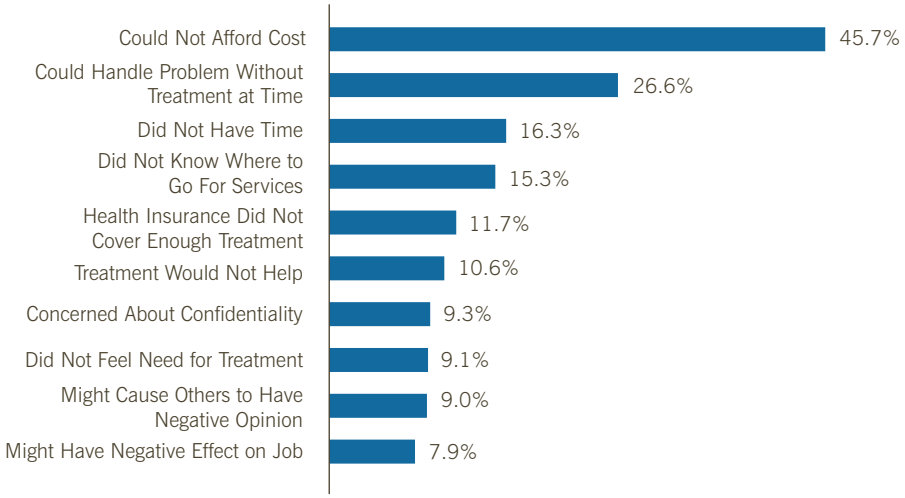
Fragmented Care Delivery and Provider Shortages Impede Effective Treatment for Behavioral Health Conditions

Behavioral health care is fragmented. Individuals who seek behavioral health care often receive treatment in both the inpatient and outpatient settings from generalists and specialists, and rely on a myriad of community resources.[39] Patients with physical health conditions can receive care from yet another group of providers who do not have linkages to those delivering behavioral health care. Even more troubling, the majority of adults with a diagnosable behavioral health disorder do not get any treatment for their behavioral health conditions.[40]

One of the biggest barriers to accessing behavioral health services is a critical shortage of treatment capacity. Currently, 55 percent of U.S. counties have no practicing psychiatrists, psychologists or social workers.[41] There also is a shortage of facilities formally providing behavioral health care. Only 27 percent of community hospitals have an organized, inpatient psychiatric unit,[42] while state and county psychiatric hospitals are closing due to state budget and other funding constraints.[43] Many states have slashed their mental health budgets.[44] Twenty-eight states and Washington, DC reduced their mental health funding by a total of $1.6 billion between fiscal years 2009 and 2012.[45]

Cost is a common barrier to receiving mental health care services.

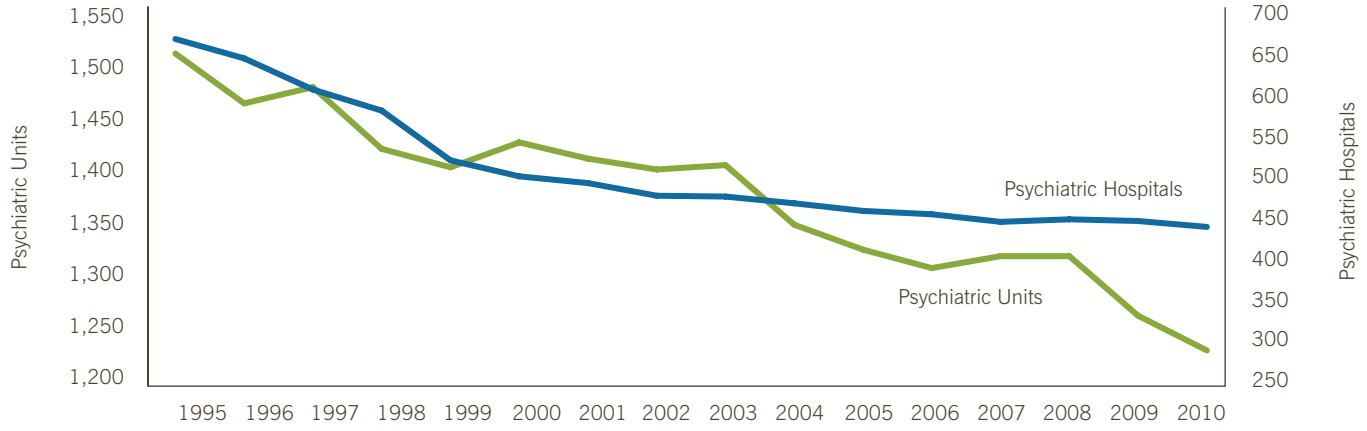
Chart 4: Reasons for Not Receiving Mental Health Services, Among Adults Reporting Unmet Need, 2009



Note: Excludes those who reported unmet need but received some services.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units(1) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals(2) in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.
(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.
Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

To achieve these cuts, states have eliminated or downsized emergency and long-term hospital treatment, and community mental health treatment programs, among other services. Colorado, for example, has reduced payment rates for mental health providers and cut funding for residential treatment.[46] States are making decisions to reduce services as demand for behavioral services is increasing. Emergency department (ED) visits involving a primary diagnosis of mental illness or substance abuse disorder increased from about 4.2 million in 2006 to more than 5 million visits in 2009.[47, 48]

Due to this increased utilization and a shortage of beds, ED boarding—the practice in which admitted patients are held in the ED until inpatient beds become available—is growing for patients with behavioral health care needs at hospitals nationwide. In 2008, 80 percent of ED medical directors surveyed reported that their hospitals board psychiatric patients and 42 percent reported a rising trend.[49] Boarding can adversely affect psychiatric patients by exacerbating their conditions, as patients are held in typically loud, hectic environments not conducive to their recovery.

Treatment Settings for Behavioral Health Care

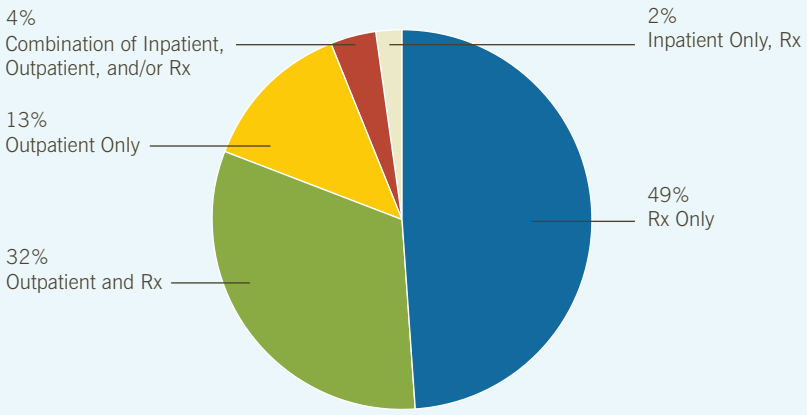
The first point of contact for individuals seeking mental health care is typically a primary care provider.[50] In fact, primary care is the sole form of health care used by more than one third of patients receiving care for a mental health condition.[51] Patients also may access mental health care through specialists (e.g., psychiatrists), social service providers (e.g., counselors) and informal volunteers (e.g., support groups).[52] Mental health services are delivered at a range of locations, including hospitals, outpatient clinics and community settings. Of the 30 million adults receiving mental health services in 2009, the most common services were outpatient therapy, outpatient prescription drugs or a combination of the two.[53]

Although mental health care is most frequently delivered on an outpatient basis, community and psychiatric hospitals remain a vital source of care for behavioral health patients.[54] Nearly all hospitals report that they provide care to patients with mental health and substance abuse disorders.[55] The most common behavioral health conditions treated in hospitals include mood disorders, substance-related disorders, delirium/dementia, anxiety disorders and schizophrenia.[56] Hospitals treat these and other conditions by stabilizing patients, establishing treatment regimens and transitioning patients to outpatient and community-based services.

Overall, about 27 percent of behavioral health care expenditures in 2005 went toward hospital-based services—inpatient care provided by community and psychiatric hospitals.[57] Psychiatric hospitals offer inpatient psychiatric and nursing services, conduct procedures and observe patients so that they do not harm themselves. Notably, the vast majority of inpatient behavioral health services are provided in community hospitals.

Treatment for behavioral health problems is most frequently delivered on an outpatient basis.

Chart 6: Types of Mental Health Services Used in Past Year, Among Adults Receiving Treatment, 2009



Note: Excludes treatment for substance abuse disorders.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Treatment Works

Despite the challenges of delivering and coordinating behavioral health care within the broader health care system, effective treatment for behavioral health conditions does exist. For instance, pharmacotherapy has become an increasingly important part of behavioral health treatment. A wave of new, effective drug treatments for depression, anxiety and schizophrenia has boosted medication as a share of mental health expenditures from 7 percent in 1986 to 27 percent in 2005. Effective drug treatments also have allowed more patients to receive care in the outpatient setting, which accounted for 33 percent of mental health expenditures in 2005, up from 24 percent in 1986.[58]

Pharmacologic treatments, such as antidepressants have been shown to improve quality of life for mental health patients.[59] Medications also are often enhanced with psychosocial treatments. Cognitive behavior therapy, in combination with psychotropic medication, has decreased symptoms of principal generalized anxiety disorder, panic disorder and social anxiety disorder.[60]

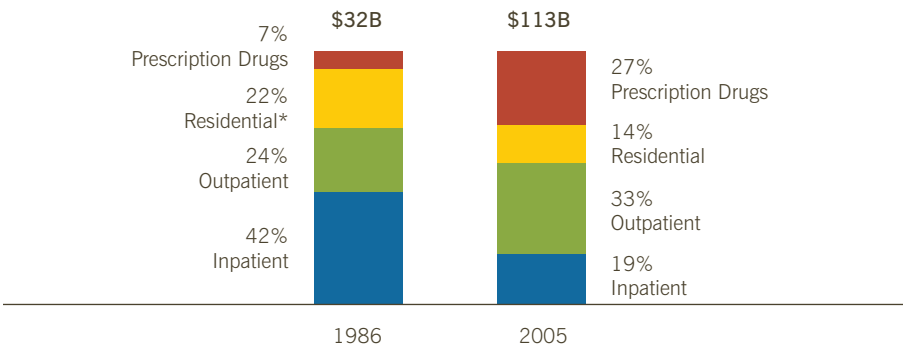
The relative ease of seeking treatment in ambulatory settings, along with shifting perceptions of behavioral health, may encourage more individuals to seek treatment. A survey comparing perceptions of major depression found that more individuals attribute the condition to neurobiological causes and endorse treatment for depression in 2006 than did in 1996.[61]

Treatment has been shown to have a positive economic impact by reducing employer costs and boosting worker productivity. In one study, work impairment of employees with mental illness (defined as when emotional distress has an impact on day-to-day functioning) was cut nearly in half after three weeks of outpatient treatment, from 31 percent to 18 percent.[62] Employer-based initiatives to increase access to mental health treatment have also proven beneficial. For example, Employee Assistance Programs have been shown to reduce medical, disability, and workers' compensation claims, improve worker productivity and decrease absenteeism.[63]

Treatment also has evolved to meet patient needs. Technological advances, such as telepsychiatry, have improved care for patients in rural and other underserved areas. Telepsychiatry—a form of video conferencing that can be used to provide psychiatric services—has been shown to be as effective as face-to-face communication,[64] as well as to increase access and diagnosis and enhance care coordination.[65]

Increased utilization of prescription drugs and decreased reliance on inpatient services has shifted spending over time.

Chart 7: Distribution of Mental Health Expenditures by Type of Service, 1986 and 2005



Note: Excludes spending on insurance administration. Data not adjusted for inflation.
* Residential treatment includes spending in nursing home units of hospitals or in nursing homes affiliated with hospitals.
Source: Substance Abuse and Mental Health Services Administration. (2011). National Expenditures for Mental Health Services & Substance Abuse Treatment 1986-2005. Washington, DC. As cited in Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

South Carolina Telepsychiatry Network

The South Carolina Department of Mental Health and the South Carolina Hospital Association received funds to develop a statewide telepsychiatry network. The program allows mental health providers to conduct psychiatric consultations via telephone and video conferencing, giving patients in 27 participating hospital EDs greater access to mental health specialists.[66] The program has produced measurable results, both in terms of patient outcomes and cost savings. The statewide average length of stay for patients experiencing a behavioral crisis across participating hospitals declined from six days to three days. One hospital, Springs Memorial, reported a savings of $150,000 in the first eight months of its participation in the service.[67]

Aleda E. Lutz VA Medical Center, Saginaw, MI

The Aleda E. Lutz Veterans Administration (VA) Medical Center in Saginaw, MI has been using telepsychiatry for the past five years to provide individual therapy and counseling as well as ongoing evaluation and assessment for behavioral health patients.[68]

Before initiating telepsychiatry, one onsite visit with the mental health professional is recommended to complete a psychosocial exam and establish a relationship. After that visit, patients are offered the option of receiving follow-up sessions using telepsychiatry. Before a telepsychiatry session begins, there is a reconciliation of all critical patient information from the electronic medical record and from recent tests and medication adjustments. The telepsychiatry technicians (THTs), who are onsite with the patients, and the health care provider at the remote site have protocols for how to handle specific situations or emergencies. For example, if a patient with post-traumatic stress disorder needs direct intervention during a session, the provider, who may be up to 150 miles away, may immediately call the THT (usually a nurse) on his/her cell phone and tell him/her to provide immediate hands-on care and evaluate the patient for appropriate care.

The number of VA rural sites using telepsychiatry is skyrocketing. Patients are very satisfied with the use of telepsychiatry especially because it can reduce their time spent driving to a medical care session by as much as three hours each way. Patient concerns about confidentiality of information being shared over the lines are allayed by the T3 encryption system as well as the very solid firewalls that are in place to protect their privacy.

The VA's 1,100 sites of care in the U.S., South Pacific and Puerto Rico are connected by an electronic medical record that allows health care providers to share information and coordinate care across sites. Substantial resources are required to support the technology and infrastructure as well as to train health care workers to use the equipment. The VA home telepsychiatry program served approximately 35,000 patients in 2009 and had $72 million in expenditures. By 2011, expenditures reached $163 million.

Integrating Behavioral Health into the Broader Care Continuum Can Reduce Costs and Improve Outcomes

The delivery of behavioral health services is usually separate from and uncoordinated with the broader health care delivery system. For individuals with comorbid behavioral and physical health conditions, this fragmentation compromises quality of care and clinical outcomes. Integration of care between the behavioral health and general medical care treatment settings and providers, can reduce costs and improve outcomes for these patients.

Integration of care can range from brief screening and intervention for comorbid conditions, to coordinated communication between medical and behavioral health providers, to full integration of care delivery across the care continuum with respect to all of the medical and behavioral health care needs of a particular patient. Integration entails both improving the screening and treatment for behavioral health care needs within primary, acute and post-acute care settings, as well as improving the medical care of people receiving services in behavioral health care settings.

One study of an integrated care model found that 44 percent of adults with a serious mental illness who received primary care services within the mental health setting had diabetes and hypertension screenings, while none of the patients without integrated care were screened. Additionally, ED visits were 42 percent lower among the group that received integrated primary care services.[69]

Another study of administration of a brief screening and intervention for substance abuse among patients admitted to a large urban hospital found a nearly 50 percent reduction in re-injuries requiring an ED visit and in injuries requiring a hospital readmission within three years.[70]

Similarly, individuals with serious mental illness enrolled in a Veterans Affairs mental health clinic who were randomized to receive integrated care were more likely to receive primary and preventive care, and demonstrated superior outcomes compared to their counterparts not receiving integrated care. Integrated care included primary care and case management given on site at the mental health clinic, patient education

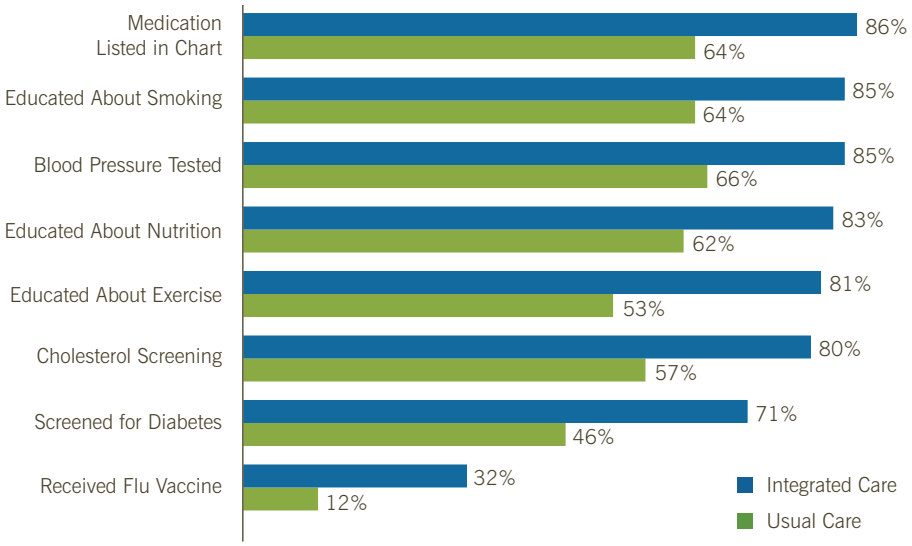
and close collaboration between physical and mental health providers.[71]

A substantial body of clinical evidence has demonstrated the benefits of collaborative care for patients with depression, in particular. A literature review of 45 studies found that patients with major depressive disorder treated with collaborative care interventions experienced enhanced treatment outcomes—including reduced financial burden, substantial increases in treatment adherence, and long-term improvement in depression symptoms and functional outcomes—compared with those receiving usual care.[72]

Integration of care across treatment settings can reduce readmission rates for patients with behavioral health conditions. In Florida, eight psychiatric hospitals partnered with a health plan to improve patients' transitions to outpatient care, with the goal of reducing preventable readmissions.

Integration of behavioral and physical health care can improve access to appropriate care.

Chart 8: Receipt of Preventive Care Services in 12 Months among Patients with Serious Psychiatric Illness Receiving Integrated Care vs. Patients Receiving Usual Care



Source: Druss, B., et al. (2001). Integrated Medical Care for Patients with Serious Psychiatric Illness. A Randomized Trial. *Archives of General Psychiatry*, 58, 861-868.

Mayo Clinic, Rochester, MN

The Mayo Clinic in Rochester, MN is delivering integrated primary and behavioral health care to more than 140,000 patients—including clinic employees, their dependents and other patients seen by Mayo's primary care physicians—using a team-based approach.[73] Mayo's employed primary care physicians, clinical nurse specialists, psychiatrists, psychologists, nurses, social workers and clinic administrators make up the patient's health care team. This team collaborates using a common patient screening tool and electronic health record to ensure the patient is receiving comprehensive primary and behavioral health care. The team also is linked with existing community-based services to ensure continuity of care for the patient.

At the initial mental health visit, patients complete self-rated scales—known as the PHQ-9 and used in a variety of health care settings nationwide—for depression, anxiety, bi-polar disorder and substance abuse which help assess the severity and urgency of the patient's condition. The patient's score on the PHQ-9 helps inform the health care team of the type of care the patient requires. The PHQ-9 also is completed at all follow-up visits for patients with depression. The health care team can adjust the patient's medication, start or increase therapy and address suicide risks based on the patient's score. Patients that receive a score of 10 or higher on the PHQ-9 are added to a registry and monitored for up to 12 months by one of Mayo's 11 registered nurse care coordinators. The care coordinators monitor the patient's condition, share their findings with the patient's psychiatrist and the health care team, assist patients with referrals to other community resources and develop a relapse prevention plan with the patient. The patients also have the opportunity to participate in a depression improvement program offered in Minnesota known as DIAMOND (Depression Improvement Across Minnesota Offering a New Direction).

Mayo's implementation of the team-based approach, the use of the PHQ-9 and the registered nurse care coordinators have significantly improved outcomes and continuity of care for patients. In 2010, two of Mayo's clinics reported the best patient outcomes in the state.

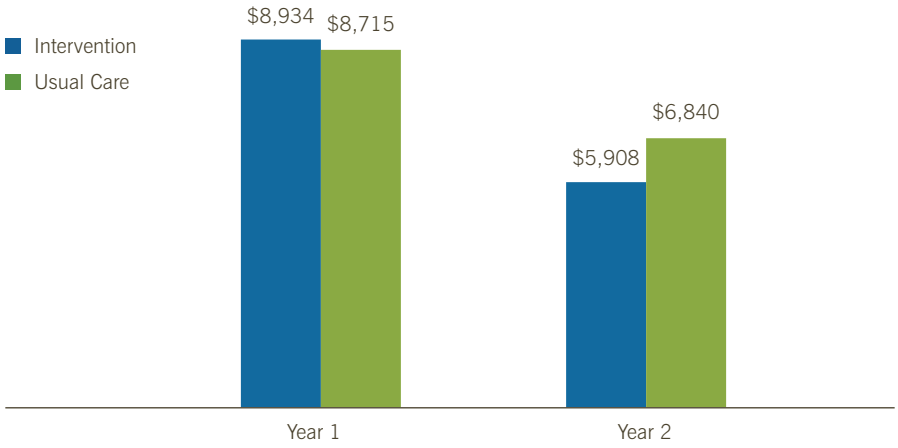
The hospitals focused on coordinating care in the inpatient setting with support services post-discharge. Their efforts cut readmission rates at the eight hospitals. After implementing the program, the readmission rate among the participating hospitals fell from 17.7 percent to 10.4 percent.[74]

Beyond improving quality of care and outcomes for patients, integrating care also can save money. In the Florida program, instituting a visit from a physician on the day of discharge reduced costs by 14 percent. Another study of a care coordination and education program, which deployed medical case managers to assist psychiatric outpatients at a community mental health center, found that participating patients had lower costs by the second year of the program than non-participating patients.[75]

Further, integration has been shown to reduce health care costs in the long term. One study found that older patients with depression who received collaborative care management from both a primary care physician and a nurse or psychologist care manager had lower mean health care costs across four years compared with patients receiving usual primary care.[76] Another study found that coordinating care for patients with diabetes and comorbid major depression through a nurse intervention reduced 5-year mean total medical costs by $3,907, compared with patients receiving usual primary care.[77]

Coordination of care can reduce costs for individuals with behavioral health conditions.

Chart 9: Total Costs at 1 and 2 Years for Patients with Serious and Persistent Mental Illnesses Receiving a Medical Care Management Intervention vs. Usual Care



Source: Druss, B.G., et al. (2011). Budget Impact and Sustainability of Medical Care Management for Persons with Serious Mental Illness. *American Journal of Psychiatry*, AiA, 1-8.

St. Anthony Hospital, Oklahoma, OK

St. Anthony Hospital in Oklahoma City, OK is an acute care inpatient hospital that serves as a regional referral facility in behavioral medicine and also offers residential inpatient care for adolescents and children. In 2008, St. Anthony initiated a number of changes to its internal processes to address the high rates of behavioral health patients admitted through its ED and to reduce the time mentally ill patients spent in the ED in a crisis situation.[78]

The hospital established a mental health admissions office in the ED and began conducting behavioral health evaluations of patients prior to bed placement in the ED. De-escalation training was conducted for all ED and security staff and the Oklahoma City Police Department was enlisted to improve and assist in the transfer of patients to the behavioral health crisis center. St. Anthony also focused on avoiding unnecessary admissions and readmissions of behavioral health patients by ensuring patients are connected with the right resources and provided the appropriate care in the appropriate setting.

As a result of these changes St. Anthony's average wait time for patients to see a mental health professional decreased from two hours to 20 minutes, and patients now see a mental health professional before seeing an ED physician. Additionally, the average wait time for patients in the ED has decreased from 44 minutes to 28 minutes. Furthermore, the average length of stay in the ED for mental health patients has dropped from 254 minutes to 177 minutes.

Although St. Anthony has recently seen an increase in patients seeking services through the ED—on average 83 more patients a month seek care in the ED—they have experienced a 12-20 percent reduction in admissions.

Affordable Care Act Provisions Will Promote Service Integration, Quality Enhancement and Improved Access for Those with Behavioral Health Care Needs

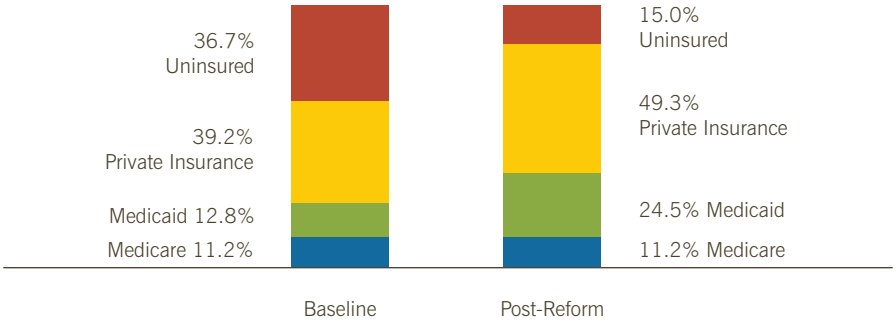
Overall, the health care system has been shifting toward a focus on value and accountability. The *Patient Protection and Affordable Care Act* (ACA)[79] furthers these efforts by promoting new care delivery models and creating new imperatives for providers to better integrate care. These ACA reforms, in addition to coverage expansion, and the previously enacted mental health parity law should facilitate the integration of behavioral health care into the broader care continuum. While many of the ACA delivery system reforms apply to Medicare and Medicaid, private insurers often adopt similar reforms once tested and found to be effective.

First, the ACA supports emerging models of care delivery—specifically accountable care organizations (ACOs) and patient-centered medical homes—that aim to coordinate and manage the full spectrum of health care needs of an individual. ACOs join physicians, hospitals and other providers to manage and be held accountable for the quality and costs of care for their patients. While ACOs are already being tested by private payers, the ACA adds the model to Medicare, giving participating providers an opportunity to share in cost savings if they meet quality goals.[80]

In the Medicaid program, the ACA creates a health home program to promote integrated care for beneficiaries with chronic ailments, including behavioral health conditions. Beneficiaries with a serious and persistent mental illness, or with a mental health or substance abuse disorder and a comorbid chronic medical condition, are eligible to participate in the health home program. Each health home will include a team of physicians and other providers, including behavioral health care professionals. In addition to medical services, the team will deliver comprehensive care management, care coordination, health promotion and other patient and family support.[81]

A substantial number of uninsured adults with mental health needs will gain coverage under health reform.

Chart 10: Simulated Change in Coverage After Reform Among Adults with Probable Depression or Serious Psychological Distress



Note: Based on data for adults ages 18-64 in the 2004-2006 Medical Expenditure Panel Surveys.
Source: Garfield, R., et al. (2011). The Impact of National Health Care Reform on Adults With Severe Mental Disorders. *American Journal of Psychiatry*, 168(5): 486-494.

Second, the ACA creates new incentives for providers to better manage patients' transitions among settings and providers of care and the community. The Hospital Readmissions Reduction Program lowers Medicare payment to hospitals with greater than expected readmissions. In the initial years, the program includes measures of all-cause readmissions for heart failure, heart attack and pneumonia.[82] Given the role that behavioral health needs play in compliance with care regimens and care seeking behaviors, and the greater likelihood of readmission among patients with a comorbid behavioral health condition, identifying and addressing behavioral health needs pre-discharge will be crucial for hospitals looking to reduce their readmission rates.

Likewise, the ACA encourages the use of bundled payment rates across acute and post-acute providers for specified episodes of care in both Medicare and Medicaid.[83] By promoting coordination across these providers, this program also could help improve care transitions for patients with behavioral health needs.

Third, the ACA sets new standards for quality of behavioral health care. The law establishes new quality measures focused on mental health care to be used in a psychiatric hospital public reporting program in Medicare. Beginning with rate year 2014, psychiatric hospitals that do not submit their data will be subject to a 2 percent payment penalty.[84] The ACA also establishes a Psychiatric Hospital Value-based Purchasing pilot program in Medicare that will test the use of incentive payments for hospitals that meet certain performance standards.[85] Finally, the ACA should help improve access to behavioral health services by expanding insurance coverage for all Americans[86] and supporting workforce[87] development grants and other efforts to expand the behavioral health care workforce. In addition to the ACA changes, the *Mental Health Parity and Addiction Equity Act of 2008* also improves coverage by requiring health insurers to apply treatment limitations, enrollee financial responsibility requirements, and in-network versus out-of-network benefits equally to behavioral health and physical health care.[88]

Conclusion

As providers take on shared accountability for health care across the continuum, they should not overlook patients' behavioral health care needs. Behavioral health disorders are prevalent among U.S. adults, and the consequences of not addressing these conditions in a coordinated fashion are poorer physical and mental health outcomes and higher health care costs.

Health care organizations and providers that can effectively integrate care across treatment settings as well as between the behavioral and physical health care systems should realize gains in quality and outcomes, and reduced treatment costs.

POLICY QUESTIONS

- How can policymakers further promote integration of behavioral and physical health care?
- Will the behavioral health provider workforce be adequate to accommodate the expected influx of new patients following coverage expansions in 2014?
- How will the distribution of behavioral health financing change under health reform? Will public payers continue to account for the majority of spending?
- How will delivery system reforms account for the unique needs of behavioral health patients? And how can they be leveraged to spur improved integration of physical and behavioral health care?

ENDNOTES

1 Kessler, R.C., et al. (2005). Prevalence, Severity and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 617-627.

2 Agency for Healthcare Research and Quality. (2009). Healthcare Cost and Utilization Project (HCUP) Nationwide Inpatient Sample (NIS), 2009. Rockville, MD.

3 Weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), 2009, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the States. Total number of weighted discharges in the U.S. based on HCUP NIS = 39,434,956.

4 U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

5 American Society of Addiction Medicine. (April 2011). Public Policy Statement: Definition of Addiction. http://www.asam.org/DefinitionofAddiction-LongVersion.html.

6 Kessler, R.C., et al. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Cormorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602.

7 The Alliance for Health Reform. Covering Health Issues Sixth Edition, Chapter 11: Mental Health and Substance Abuse.

8 Kessler, R.C., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51(1), 8-19.

9 Yu, H., et al. (August 2011). Hospitals Stays for Children, 2009. Agency for Healthcare Research and Quality. Statistical Brief #118. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb118.jsp.

10 Donohue J. (2006). Mental Health in the Medicare Part D Drug Benefit: A New Regulatory Model? *Health Affairs*, 25(3), 707-19.

11 Ireys, H., et al. (September 2010). Medicaid Beneficiaries Using Mental Health or Substance Abuse Services in Fee-for-Service Plans in 13 States, 2003. *Psychiatric Services*, 61(9), 871-877.

12 Russell, L. (October 2010). *Mental Health Care Services in Primary Care Tackling the Issues in the Context of Health Care Reform*. Washington, DC: Center for American Progress.

13 American Hospital Association. (February 2007). *Community Hospitals: Addressing Behavioral Health Care Needs*.

14 Lépine, J.P., and Briley, M. (May 2011). The Increasing Burden of Depression. *Neuropsychiatric Disease and Treatment*, 7, 3-7.

15 Hogg Foundation for Mental Health/Methodist Healthcare Ministries. (March 2011). Crisis Point: Mental Health Workforce Shortages in Texas. http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf.

16 Hertz, R.P., and Baker, C.L. (2002). The Impact of Mental Disorders on Work. *Pfizer Outcomes Research.*

17 Cost was translated from 1999 to 2010 dollars using the GDP deflator as reported by the Bureau of Economic Analysis.

18 Russell, L. (October 2010). *Mental Health Care Services in Primary Care Tackling the Issues in the Context of Health Care Reform*. Washington, DC: Center for American Progress.

19 Hogg Foundation for Mental Health/Methodist Healthcare Ministries. (March 2011). *Crisis Point: Mental Health Workforce Shortages in Texas*. http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf.

20 Agency for Healthcare Research and Quality. (September 2009). *Mental Health Research Findings*. Rockville, MD.

21 http://meps.ahrq.gov/mepsweb/data_files/publications/st331/stat331.pdf; and Russell, L. (October 2010). *Mental Health Care Services in Primary Care Tackling the Issues in the Context of Health Care Reform*. Washington, DC: Center for American Progress.

22 Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

23 Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

24 Carney, C.P., and Jones, L.E. (2006). Medical Comorbidity in Women and Men with Bipolar Disorders: A Population-based Controlled Study. *Psychosomatic Medicine*, 68, 684-691.

25 New York State Health Foundation. (April 2011). *Grant Outcomes Report: Improving Chronic Illness Care in New York State*.

26 Patten, S. (March 2001). Long-term Medical Conditions and Major Depression in a Canadian Population Study at Waves 1 and 2. *Journal of Affective Disorders*, 63, 35-41.

27 Bush, D.E., et al. (2005). *Post-myocardial Infarction Depression*. Evidence Report Technology Assessment. Number 123. Rockville, MD: Agency for Healthcare Research and Quality.

28 DiMatteo, M.R., Lepper, H.S., and Croghan, T.W. (2000). Depression Is a Risk Factor for Noncompliance with Medical Treatment: Meta-analysis of the Effects of Anxiety and Depression on Patient Adherence. *Archives of Internal Medicine*, 160, 2101-2107.

29 Carney, C.P., and Jones, L.E. (2006). Medical Comorbidity in Women and Men with Bipolar Disorders: A Population-based Controlled Study. *Psychosomatic Medicine*, 68: 684-691.

30 Melek, S., and Norris, D. (2008). *Chronic Conditions and Comorbid Psychological Disorders*. Cited in: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

31 Colton, C.W., and Manderscheid, R.W. (April 2006). Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, 3(2).

32 National Association of State Mental Health Program Directors. (October 2006). Morbidity and Mortality in People with Serious Mental Illness.

33 Nasrallah, H.A., et al. (2006). Low Rates of Treatment for Hypertension, Dyslipidemia and Diabetes in Schizophrenia: Data from the CATIE Schizophrenia Trial Sample at Baseline. *Schizophrenia Research*, 86, 15-22.

34 Madi, N., et al. (2007). Hospital Readmissions for Patients with Mental Illness in Canada. *Healthcare Quarterly*, 10(2).

35 Irmiter, S., et al. (2009). Sixteen-Year Predictors of Substance Use Disorder Diagnoses for Patients with Mental Health Disorders. *Substance Abuse*, 30(1), 40-46.

36 Frasure-Smith, N., et al. (2000). Depression and Health-care Costs During the First Year Following Myocardial Infarction. *Journal of Psychosomatic Research*, 48, 471-478.

37 Volz, A., et al. (July 2010). Predictors of Readmission and Health Related Quality of Life in Patients with Chronic Heart Failure: A Comparison of Different Psychosocial Aspects. *Journal of Behavioral Medicine*, 34, 113-122.

38 James, S., et al. (2010). Post-discharge Services and Psychiatric Rehospitalization among Children and Youth. *Administration and Policy Mental Health*, 37, 433-445.

39 Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

40 Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

41 National Alliance on Mental Illness. (January 2011). *Workforce Development: Policy Brief*. http://www.nami.org/Template.cfm?Section=About_the_Issue&Template=/ContentManagement/ContentDisplay.cfm&ContentID=114129.

42 American Hospital Association. (2007). *Behavioral Health Challenges in the General Hospital: Practical Help for Hospital Leaders*. Washington, DC.

43 Johnson, A. (June 26, 2008). Two Psychiatric Hospitals Closing over Budget Cuts. *Columbus Dispatch*. http://www.dispatch.com/live/content/local_news/stories/2008/06/26/HOSPITAL_CLOSINGS.ART_ART_06-26-08_B2_HNAJB21.html?sid=101.

44 Honberg, R., et al. (2011). *State Mental Health Cuts: A National Crisis*. Arlington, VA: National Alliance on Mental Illness.

45 Honberg, R., et al. (November 2011). *State Mental Health Cuts: The Continuing Crisis*. Arlington, VA: National Alliance on Mental Illness.

46 Johnson, N., et al. (February 9, 2011). An Update on State Budget Cuts: At Least 46 States Have Imposed CutsThat Hurt Vulnerable Residents and Cause Job Loss. Washington, DC: Center on Budget and Policy Priorities.

47 Agency for Healthcare Research and Quality. (2009). Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department (NEDS), 2009. Rockville, MD.

48 Weighted national estimates from HCUP Nationwide Emergency Department (NEDS), 2009 Agency for Healthcare Research and Quality (AHRQ), based on data collected from the HCUP State Emergency Department Databases (SEDD) and the State Inpatient Databases (SID). Total number of weighted visits in the U.S. based on HCUP NEDS = 128,885,040.

49 Department of Health and Human Services. (October 2008). *A Literature Review: Psychiatric Boarding*.

50 Mechanic, D., and Bilder, S. (2004). Treatment of People with Mental Illness: A Decade-Long Perspective. *Health Affairs*, 23(4): 84-95.

51 Russell, L. (October 2010). *Mental Health Care Services in Primary Care Tackling the Issues in the Context of Health Care Reform*. Washington, DC: Center for American Progress.

52 Sundararaman, R. (April 2009). *The U.S. Mental Health Delivery System Infrastructure: A Primer*. Washington, DC: Congressional Research Service.

53 Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

54 Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

55 Agency for Healthcare Research and Quality. (January 2007). *Care of Adults with Mental Health and Substance Abuse Disorders in U.S. Community Hospitals*, 2004. Rockville, MD.

56 Agency for Healthcare Research and Quality. (January 2007). *Care of Adults with Mental Health and Substance Abuse Disorders in U.S. Community Hospitals*, 2004. Rockville, MD.

57 Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

58 Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

59 Lehman, A.F., et al. (2004). *Evidence-based Mental Health Treatments and Services: Examples to Inform Public Policy*. New York: Milbank Memorial Fund.

60 Craske, M., et al. (April 2011). Disorder-specific Impact of Coordinated Anxiety Learning and Management Treatment for Anxiety Disorders in Primary Care. *Archives of General Psychiatry*, 68(4), 378-388.

61 Pescosolido, B., et al. (November 2010). "A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence. *American Journal of Psychiatry*, 167(11), 1321-1330.

62 Partnership for Workplace Mental Health. (2006). *A Mentally Healthy Workforce—It's Good for Business*, Cited in: National Alliance on Mental Illness. (January 2010). *The High Costs of Cutting Mental Health: Mental Illness and the Workplace*. Arlington, VA.

63 Employee Assistance Society of North America (2009). *The Value of Employee Assistance Programs*, Cited in: National Alliance on Mental Illness. (January 2010). *The High Costs of Cutting Mental Health: Mental Illness and the Workplace*. Arlington, VA.

64 Frueh, C., et al. (2007). A Randomized Trial of Telepsychiatry for Post-Traumatic Stress Disorder. *Journal of Telemedicine and Telecare*, 13(3), 142-147.

65 Office of Rural Health and Primary Care. (July 2010). Rural Health Advisory Committee's Report on Telemental Health in Rural Minnesota. St. Paul: MN: Minnesota Department of Health.

66 South Carolina Department of Mental Health. DMH Telepsychiatry Program: Participating Hospitals. http://www.state.sc.us/dmh/telepsychiatry/cover_sheets.html.

67 South Carolina Department of Mental Health. (October 25, 2010). DMH Telepsychiatry Consultation Program Overview. http://www.state.sc.us/dmh/telepsychiatry/program_overview.pdf.

68 American Hospital Association personal communication with Robert Dorr, DO, JD, Chief of Staff, Aleda E. Lutz VA Medical Center, Saginaw, MI.

69 Boardman, J. (2006). Health Access and integration for Adults with Serious and Persistent Mental Illness. *Families, Systems, & Health*, 24(1), 3-18.

70 Gentilello, L., et al. (1999). Detection of Acute Alcohol Intoxication and Chronic Alcohol Dependence by Trauma Center Staff. Cited in: Mauer, B.J., and Druss, B.G. (2010). Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface. *Journal of Behavioral Health Services & Research*, 37(4), 529-542.

71 Druss, B., et al. (2001). Integrated Medical Care for Patients with Serious Psychiatric Illness. A Randomized Trial. *Archives of General Psychiatry*, 58, 861-868.

72 Katon, W., and Guico-Pabia, C. (2011). Improving Quality of Depression Care Using Organized Systems of Care: A Review of the Literature. *The Primary Care Companion for CNS Disorders*, 13(1).

73 American Hospital Association personal communication with David Katzelnick M.D., Chair, Integrated Behavioral Health Division, Mayo Clinic, Rochester, MN.

74 Agency for Healthcare Research and Quality. (February 2011). Health Plan and Psychiatric Hospitals Reduce Readmissions by Reviewing Data and Developing Strategies to Improve Postdischarge Care. http://www.innovations.ahrq.gov/content.aspx?id=3082#1.

75 Druss, B.G., et al. (2011). Budget Impact and Sustainability of Medical Care Management for Persons with Serious Mental Illness. *American Journal of Psychiatry*, AiA, 1-8.

76 Unutzer, J., et al. (2008). Long-Term Cost Effects of Collaborative Care for Late-life Depression. *American Journal of Managed Care*, 14(2), 95-100.

77 Katon, W., et al. (June 2008). Long-Term Effects on Medical Costs of Improving Depression Outcomes in Patients With Depression and Diabetes. *Diabetes Care*, 31(6), 1155-1159.

78 American Hospital Association personal communication with Larry Philips, D.C.S.W., Program Manager Behavioral Health, St. Anthony Hospital, Oklahoma City, OK.

79 The Affordable Care Act is the combination of the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

80 Affordable Care Act. Public Laws 111-148 & 111-152. §3022.

81 Affordable Care Act. Public Laws 111-148 & 111-152. §2703.

82 Affordable Care Act. Public Laws 111-148 & 111-152. §3025.

83 Affordable Care Act. Public Laws 111-148 & 111-152. §2704 and §3023

84 Affordable Care Act. Public Laws 111-148 & 111-152. §3401.

85 Affordable Care Act. Public Laws 111-148 & 111-152. §10326.

86 Affordable Care Act. Public Laws 111-148 & 111-152. See Title I and §2001.

87 Affordable Care Act. Public Laws 111-148 & 111-152. See, for example, §§5101, 5204, and 5306.

88 Congressional Research Service. *CRS Mental Health Parity Report on the PPACA of 2010*. Washington, DC.

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TrendWatch – January 2012

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