

ACHIEVING INTEGRATED CARE IN NORTH CAROLINA

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

July, 2009

Governor Perdue's Agenda

Governor Perdue has been very clear that one of her goals is to deliver 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 Division 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 (Integrated, Collaborative, Accessible, Respectful, and Evidence-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 (psychiatrists and licensed psychologists, social workers, counselors, addictions

specialists, psychiatric advanced practice nurses and psychiatric physician assistants) 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 three years, and with the support of the Office of Rural Health and Community Care and funding from Astra Zeneca, the Duke Endowment, the Kate B. Reynolds Charitable Trust, and the NC Department of Health and Human Services; ICARE has in effect become a Center of Excellence for Integrated Care, including:

- Developing a very successful website (www.icarenc.org).
- Implementing many model programs (including collaboration with Community Care of North Carolina).
- Providing more than 70 regional trainings to 1500 medical and 500 behavioral health providers as well as on-site technical assistance to over 30 medical practices.
- 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, identifying key policy and process issues which must be addressed for the Governor's objectives for integrated care to be fully realized in North Carolina.

The Critical Need for Addressing Policy Barriers to Full, Statewide Implementation of Integrated Care

- Most treated patients (adults and children) suffering from depression, anxiety, substance abuse and ADHD are seen only by their primary care physician.
- Referrals by primary care providers to specialists are often, for many reasons, difficult.
- Many patients with depression, anxiety and substance abuse disorders are not treated at all; most health care providers do not routinely screen for these conditions despite their prevalence.
- Children and adults 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 behavioral health disorders.
- Patients with severe mental illnesses have as much as a 25 year 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.

- 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. Integrated care is also consistent with the national movement towards Patient-Centered Medical Homes.

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. Integrated Care 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 charged with addressing those barriers. While there are many talented individuals in state leadership positions who are committed to integrated care, it is often extremely challenging to focus the energy and resources to move issues forward. An Intergovernmental Task Group, accountable to the Governor or 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 Group. 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 this Task Group 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 and CCNC integration projects, there is no 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; and 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 children and 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 psychiatric advanced practice nurses and psychiatric physician assistants must be trained to work in integrated care sites.
- MH/DD/SA provider organizations must be trained to screen and monitor the medical status of their consumers and collaborate with health providers.
- There is a lack of available well trained specialty mental health professionals, especially in the rural areas of the state. This issue has proven to be a limiting factor in the overall success of integrated care. Therefore, significant workforce development is needed for these specialty professions. Special attention needs to be given to developing the capacity of mental health specialty providers to serve children from birth to age 5.

The Intergovernmental 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 plan (e.g. University graduate programs, AHEC, postgraduate certification and continuing education programs, ICARE, professional associations), but there is a need for direction which is guided by North Carolina's behavioral health priorities.

4. Payment Barriers:

We are pleased that the passage of the North Carolina and federal parity legislation has improved access to behavioral health services. In addition, the Division of Medical Assistance has recently approved the use of a number of new behavioral health codes which will make integrated care more sustainable while holding the promise of constraining overall health care costs. A payment system should support interventions which are most likely to achieve positive outcomes for patients at a reasonable cost. Some of the remaining barriers include the following:

- Screening: Routine developmental screening (including more recently, standardized screening for autism) exemplifies what can be accomplished in a cost-effective manner. Yet, while primary care providers deliver over half of mental health treatment in this country, they fail to identify many of the mental 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 payment support for routine screening of patients for anxiety, depression and substance abuse. National billing codes already exist for screening, but many payers (NC Medicaid is a notable exception) do not reimburse for this activity.
- 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 guidelines exist for how frequently follow-up should be done. Offices which follow the protocols should be appropriately reimbursed.
- Behavioral interventions to prevent or mitigate chronic medical conditions: Behavioral health CPT codes exist which encourage primary care providers and their behavioral specialist employees 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 (again, NC Medicaid is the model).
- Diagnosis: Some payers reimburse primary care providers at reduced rates when they treat psychiatric diagnoses. This reimbursement differential is unjustified.
- Carve out exclusions: Some insurance companies have carved out benefits which disallow payment to primary care providers for providing services to people with a MH diagnosis. Assist private insurance companies to review this and other practices which prevent adequate integration of services.
- Same day billing exclusions: Amend FQHC and private insurance policies that prevent same day billing for two different medical services.
- Telephone consultation between psychiatrists or advanced practice psychiatric nurses 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 paid and consideration should be given to regional telepsychiatry services, possibly linked with regional AHECs and the medical schools.
- Other uses of telemedicine: Extend telemedicine payment to licensed behavioral health therapists to utilize telemedicine technology.

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

- New guidelines should be developed in priority behavioral health areas. Among those which might be considered are depression, anxiety, ADHD and substance abuse.
- Guidelines should be developed for monitoring the health status of individuals with severe mental illnesses and substance use disorders. These guidelines should be known to all behavioral health providers serving this population.
- DMH/DD/SAS has been promoting selected best practice interventions for individuals with significant behavioral problems. Primary care providers should be made aware of which evidence-based interventions 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, the Intergovernmental Task Group should encourage the group to consider expanding their focus, possibly beginning with depression.
- Finally, the Task Group 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. Department officials are currently developing strategies to address some of the modifiable regulatory barriers. 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 and CCNC 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 Intergovernmental Task Group 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.
- DMH/DD/SAS should provide guidance regarding the essential information behavioral specialists and facilities should be sharing with primary care providers.
- Federal substance abuse confidentiality regulations are overly restrictive 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."
- DHHS should assume a leadership role in facilitating interconnection of mental health/primary care provider electronic health records.

In this challenging economic environment, integrated care offers an opportunity to improve care without increasing healthcare costs. We are very excited about what already has been accomplished, and look forward to joining the Governor in her efforts to promote better health for all North Carolinians.