Dear Mr. President and Mr. Vice President:

On behalf of our nearly 5,000 hospitals, health care systems, networks, other providers of care, including more than 1,600 behavioral health service providers and 43,000 individual members, the American Hospital Association (AHA) is pleased to answer your call to help raise awareness about mental health in communities across the country. Your effort is consistent with the vision of the AHA: “A society of healthy communities, where all individuals reach their highest potential for health.” Too often, adults and children suffering from mental illness and addictive disorders are not able to reach their highest potential for health. The AHA believes that by bringing attention to mental health and the stigma often associated with behavioral health and addictive disorders, individuals, families and the public will have a better understanding of the services and resources available in their communities.

The statement “all health care is local” is especially accurate for behavioral health services. Indeed, people with behavioral and substance abuse disorders depend on a broad continuum of social services agencies and state-supported services to support their treatment and recovery. However, individuals with mental illness and addictive disorders are sometimes invisible because of their often marginal economic situation and the social stigma of their disorder. Their prevalence is underappreciated.

Hospitals play a central role in the delivery of health care and are uniquely positioned to navigate the behavioral health resources that are available within communities. Psychiatric and community hospitals are a vital source of care for behavioral health patients, providing treatment for mood disorders, substance-related disorders, delirium/dementia, anxiety disorders and schizophrenia. Hospitals address these and other conditions by stabilizing patients, establishing treatment regimens and transitioning patients to outpatient and community-based services. Demand for behavioral care services in hospitals continues to grow. In 2010, mood disorders were among the ten most frequent primary diagnoses for inpatient hospital stays for both children and adults, according to data analyzed by the Agency for Healthcare Research and Quality.
The AHA and its Section for Psychiatric and Substance Abuse Services work to promote the understanding and importance of behavioral health care in the continuum of care. Hospitals often share with one another the innovative strategies they employ to help increase awareness of and improve access to behavioral health services. In fact, a number of community and psychiatric hospitals have established programs to address the behavioral health needs in their community. For example:

- **JPS Health Network, Fort Worth, Texas**: JPS Health Network is a founding member of the Mental Health Connection of Tarrant County (MHC). MHC is a partnership of public and private agencies, as well as individuals in need of behavioral health services and their family members, that was formed in the aftermath of a mass shooting. The organization came together to develop a formal mental health service delivery system for its community. MHC members assess the short- and long-term behavioral health needs for the community and provide the resources and supports necessary to care for those who require assistance. In addition, MHC engages its community through a number of initiatives, such as anti-stigma campaigns, and provides a foundation for evaluating research and evidence-based practices to ensure the implementation of appropriate supports, programs and services.

- **Kentucky One Health, Louisville, Kentucky**: KentuckyOne Health is using a grant from Catholic Health Initiatives’ Mission and Ministry Fund to integrate behavioral health into its existing Care Transitions Program. The Care Transitions Program uses nurse navigators and community health workers to help improve health outcomes for recently discharged Medicaid beneficiaries and uninsured patients at high risk for readmission. Because behavioral health is integrated into this program, patients suffering from mental health or addictive disorders will work with specialized peer counselors to learn how to better manage their treatment and recovery at home.

- **Linden Oaks at Edward, Naperville, Illinois**: Linden Oaks, a 108-bed behavioral health provider, is a pioneer in Mental Health First Aid training. Their facility has developed and trained our nation’s largest fellowship of Mental Health First Aid instructors, who are equipped to identify and respond to early signs of mental illness and substance abuse disorders. In less than three years, Linden Oaks has trained nearly 3,000 individuals representing a diverse cross-section of the community, including teachers, first responders, nurses, clergy, public health employees and business managers. A local cable network further expands the program’s reach by providing monthly programming on mental health first aid.

- **Memorial Hospital of Gulfport/Memorial Behavioral Health, Gulfport, Mississippi**: Memorial Behavioral Health established a school-based therapy program in the wake of Hurricane Katrina. The program was initiated in an effort to provide free mental health and post-traumatic stress disorder (PTSD) counseling sessions to the children who were most impacted by the storm. The school-based setting allowed for care to be provided in a comfortable, accessible environment with parental and staff involvement. A partnership with the University of Southern Mississippi’s Marriage and Family Therapy Department has provided additional therapists, allowing Memorial to expand its efforts. Since 2006, Memorial’s school-based therapy program has completed more than 16,500 counseling
sessions to help students and families dealing with depression and PTSD following more recent tragedies such as the Deepwater Horizon oil spill.

- **St. Charles Health System, Bend, Oregon:** For three years, St. Charles Health System has placed psychologists, referred to as Behavioral Health Consultants, into pediatric physician practices to provide mental health screenings and counseling services for children and their families. By integrating behavioral health into a primary care setting, families have immediate access to intervention and support provided by highly qualified mental health professionals. As a result, Behavioral Health Consultants are able to intervene at the first signs of mental health and behavioral concerns. Efforts are currently underway to expand this integrated care model to rural communities through telemedicine support, and also schools via onsite mental health screenings.

These are only a few of the many cases of hospitals across the country employing creative approaches to broaden awareness and access to mental health and substance abuse services. Hospitals and other behavioral health providers have stepped up to fill gaps in care that have grown as mental health care transitioned away from public institutions to community settings. However, some facilities were compelled to establish these and other inventive care approaches in response to declining financial support at both the state and federal levels. The National Alliance on Mental Illness found that states cut $1.6 billion in spending on mental health services between FY 2009 and FY 2012. These reductions in funding were on top of previous actions by states that eliminated or downsized emergency and long-term hospital treatment and community mental health treatment programs, among other services.

The Medicaid program also serves as our nation’s behavioral health care safety net. As the largest payer of behavioral health services, Medicaid funds many of the community-based services and resources that are part of a complex, and often fragmented, behavioral health care system. Over the past few years, Medicaid funding has been cut dramatically as states struggle to balance their budgets. As a result, a majority of states have reduced Medicaid funding and cut rates paid to hospitals and other providers. Moreover, the sluggish economy has many governors and state legislatures considering additional Medicaid spending reductions to address looming deficits, and some are seeking greater flexibility in managing their programs to rein in costs. Given the recent data indicating that the number of Medicaid beneficiaries being admitted to hospitals for mood disorders is increasing, these actions place additional stress on hospitals.

At the same time, hospitals continue to absorb payment reductions at the federal level, with repeated cuts to Medicare reimbursements, including the two percent sequester cut mandated by the **Budget Control Act**. The prospect of additional reductions to federal payments looms large with upcoming fiscal deadlines, such as the need to increase the debt limit and the expiration of the Medicare physician payment fix. Furthermore, the health reform law reduces both Medicaid and Medicare disproportionate share hospital (DSH) payments to hospitals. These payments provide vital financial support to hospitals that serve the nation’s most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured. Because the **Patient Protection and Affordable Care Act** (ACA) was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress deemed it appropriate to cut both Medicaid and Medicare DSH payments to hospitals. However, as your budget request for FY 2014 reflects, with the uncertainty of state governments’ decisions on Medicaid expansion, the promise of health care coverage improvements may not be realized for
June 3, 2013

some years to come. Given these factors, the AHA supports delaying the DSH cuts for two years to allow for coverage expansions to be more fully realized and better data to become available.

Declining reimbursements from payers and the erosion of public funding have resulted in reductions and/or eliminations of inpatient psychiatric units and/or beds in hospitals as well as in private, free-standing and state behavioral health facilities. Many outpatient centers also have closed, and some behavioral health specialists are limiting their practices to fee-for-service patients only. As a result, individuals suffering from mental health and substance abuse conditions increasingly turn to hospital emergency departments for care.

The ACA’s investments in behavioral health are worthy steps in the right direction. The health reform law creates new opportunities to better manage 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. 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. The attached AHA TrendWatch report, Bringing Behavioral Health Into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, provides more information and case examples for your administration to consider.

We will continue to need support from public partners to bolster the efforts of hospitals, behavioral health providers, and others to increase access to care. Adequate support from Medicare and Medicaid is essential if hospitals are to continue offering the array of services their communities have come to expect and depend on. In addition, a stronger commitment from government is needed to help overcome the critical shortages of workforce and treatment capacity that exists across the country.

Finally, the AHA appreciates your executive action committing to the release of final regulations for the Mental Health Parity and Addiction Equity Act. A final rule is needed to prevent health plans from applying pre-authorization requirements to mental health and substance abuse benefits, among other issues. We look forward to the issuance of this guidance in the near future.

The AHA applauds your commitment to initiate a national conversation about mental health and addressing stigmas and barriers to care, and welcomes the opportunity to work with your administration to meet these important challenges.

Sincerely,

//s//

Rich Umbdenstock
President and CEO

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

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. 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.

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.

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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. An estimated 22.5 million Americans suffered with substance abuse or dependence in 2009, and 27 percent of Americans will suffer from a substance abuse disorder during their lifetimes. 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. Studies reveal that approximately 17 percent of Medicare beneficiaries have a mental illness. An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year.

The economic and social costs associated with behavioral health are significant, underscoring the importance of treating these conditions. In the majority of cases, behavioral health conditions are serious enough to cause limitations in daily living and social activities. For example, behavioral health conditions hinder worker productivity and raise absenteeism, resulting in reduced income...
or unemployment. In 2007, persons diagnosed with serious mental illness had annual earnings averaging $16,000 less than the general population. 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.

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. Lack of treatment amplifies these outcomes and increases the likelihood that individuals will end up homeless or incarcerated.

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. In 2008, the U.S. spent nearly $60 billion on mental health services, up from $35 billion in 1996. 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.

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. 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. 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.

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. 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. Depressed patients also are three times more likely than non-depressed patients to be noncompliant with treatment recommendations. 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.

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

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

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

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.

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. Individuals with serious mental illness die, on average, 25 years earlier than the general population. 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.

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. In addition, individuals with substance use disorders are among the highest-risk populations for medical and psychiatric rehospitalizations.

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. Another study concluded that patients with severe anxiety had a threefold risk of cardiac-related readmission, compared to those without anxiety.

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. 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.
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. 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.

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. There also is a shortage of facilities formally providing behavioral health care. Only 27 percent of community hospitals have an organized, inpatient psychiatric unit, while state and county psychiatric hospitals are closing due to state budget and other funding constraints. Many states have slashed their mental health budgets. Twenty-eight states and Washington, DC reduced their mental health funding by a total of $1.6 billion between fiscal years 2009 and 2012.

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could Not Afford Cost</td>
<td>45.7%</td>
</tr>
<tr>
<td>Could Handle Problem Without Treatment at Time</td>
<td>26.6%</td>
</tr>
<tr>
<td>Did Not Have Time</td>
<td>16.3%</td>
</tr>
<tr>
<td>Did Not Know Where to Go For Services</td>
<td>15.3%</td>
</tr>
<tr>
<td>Health Insurance Did Not Cover Enough Treatment</td>
<td>11.7%</td>
</tr>
<tr>
<td>Treatment Would Not Help</td>
<td>10.6%</td>
</tr>
<tr>
<td>Concerned About Confidentiality</td>
<td>9.3%</td>
</tr>
<tr>
<td>Did Not Feel Need for Treatment</td>
<td>9.1%</td>
</tr>
<tr>
<td>Might Cause Others to Have Negative Opinion</td>
<td>9.0%</td>
</tr>
<tr>
<td>Might Have Negative Effect on Job</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Note: Excludes those who reported unmet need but received some services.

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.
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 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

### 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

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**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

<table>
<thead>
<tr>
<th>Year</th>
<th>Prescription Drugs</th>
<th>Residential</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>7%</td>
<td>22%</td>
<td>24%</td>
<td>42%</td>
</tr>
<tr>
<td>2005</td>
<td>27%</td>
<td>14%</td>
<td>33%</td>
<td>19%</td>
</tr>
</tbody>
</table>

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.

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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Integrated Care</th>
<th>Usual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Listed in Chart</td>
<td>64%</td>
<td>86%</td>
</tr>
<tr>
<td>Educated About Smoking</td>
<td>64%</td>
<td>85%</td>
</tr>
<tr>
<td>Blood Pressure Tested</td>
<td>66%</td>
<td>85%</td>
</tr>
<tr>
<td>Educated About Nutrition</td>
<td>62%</td>
<td>83%</td>
</tr>
<tr>
<td>Educated About Exercise</td>
<td>53%</td>
<td>81%</td>
</tr>
<tr>
<td>Cholesterol Screening</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td>Screened for Diabetes</td>
<td>46%</td>
<td>71%</td>
</tr>
<tr>
<td>Received Flu Vaccine</td>
<td>12%</td>
<td>32%</td>
</tr>
</tbody>
</table>


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.\(^7^4\)

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.\(^7^5\)

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.\(^7^6\) 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.\(^7^7\)

### 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.\(^7^8\)

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.
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

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Post-Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>36.7%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>39.2%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>12.8%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Medicare</td>
<td>11.2%</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

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.

ENDNOTES


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.


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


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

