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Health reform and the Affordable Care Act: The importance of mental health treatment to achieving the triple aim

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Health reform efforts in the United States, including development of the chronic care model [1], the primary care medical home [2], pay-for-performance initiatives [3], and federally-funded Medicare demonstration projects preceded the passage of the federal 2010 Accountable Care Act (ACA). In addition to expanding health care coverage to uninsured populations in many states, the ACA provides recommendations to the Centers for Medicare and Medicaid Services (CMS) to test new payment and delivery models such as the Patient Centered Medical Home (PCMH) or Health Home models and Accountable Care Organizations in an to attempt to improve quality and outcomes of health care. Although Medicare (federally-funded insurance covering Americans 65 years of age and those with chronic disabilities) and Medicaid (largely state-funded, covering low income Americans and those with certain disabilities) are government-funded programs, many commercial insurers are following the CMS lead to incentivize these changes in health care.

These ongoing health reform initiatives including the gradual implementation of the ACA are rapidly changing the health care system. The “true north” of health reform is to achieve the triple aim, including improving access to and satisfaction with care, improving quality and outcomes of care, and reducing total health care costs [4]. Given the high rate of mental health and substance abuse disorders in primary care and the high prevalence of psychiatric comorbidity among persons with chronic medical illness, these reform efforts will be enhanced by integration of behavioral health services into these initiatives. Indeed, given the high total health care costs of patients with mental illness, it will be difficult to “bend the cost curve” in the United States without improving the quality of behavioral health care in primary care, specialty medical care, and hospital populations. This article will describe the most important health reform changes and the importance of integrating mental health services into each of these efforts. We will specifically highlight the role of integrated mental health in the context of micro-level innovations, such as the Patient Centered Medical Home/Health Home model as well as macro-level innovations, such as Accountable Care.

Patient-Centered Medical Home (PCMH)

The key principles of the PCMH are to utilize the potential benefits of primary care, including timely access to care, continuity of care, and coordination and comprehensiveness of care [2]. The PCMH concept was developed to help achieve these goals and to improve quality of chronic illness care [2]. These changes often involve the use of electronic health

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records and other information technologies to facilitate panel management and effective communication and collaboration between primary care providers, specialists, and hospital systems. Other potential changes include being able to spend more time with patients by limiting number of patients seen and using allied health professionals to work in teams with primary care providers [2,5].

Both government and private health insurers in the United States are incentivizing primary care systems to make changes to meet PCMH requirements. In the United States, a prominent regulatory agency, the National Committee for Quality Assurance (NCQA), has developed criteria for levels of adaptation of practices to the medical home concept (see www.ncqa.org) [6]. The 2011 NCQA criteria for becoming a Level 2 medical home require evidence of quality improvement efforts for two chronic medical conditions and at least one behavioral condition such as depression [6]. Health insurers are beginning to provide higher payments to systems of care that can meet Level 2, and later Level 3, medical home requirements. A recent NCQA report also emphasized the importance of integrated care for mental health problems for “dually eligible” patients who qualify for Medicare and Medicaid benefits [7].

The ACA will expand Medicaid coverage to uninsured patients in many states and has a provision to provide states with additional federal funding to pay for development of Health Homes (closely related to the PCMH concept) for clinic systems that care for the majority of Medicaid patients. Federal funds will be available to pay for care management, coordination of care with community agencies and medical specialists and use of information technologies [8].

Gaps in quality of mental health care in primary care systems

Approximately 20 to 25% of primary care patients have one or more psychiatric disorders—most commonly anxiety, depressive, and alcohol/substance abuse disorders [9]. Prevalence rates are approximately two fold higher in uninsured or Medicaid populations [10]. Patients with these mental health disorders have more medically unexplained symptoms, such as headache and abdominal discomfort [11], utilize more primary care and specialty visits [12,13], and have almost two-fold higher medical costs [12,13]. Patients with chronic conditions such as diabetes and coronary heart disease have approximately two-fold higher rates of anxiety and depressive disorders as other primary care patients [14,15]. Both comorbid depressive/anxiety disorders, as well as more minor psychological distress, can impair self-care for acute and chronic medical conditions (such as adherence to medications, diet, and exercise) [16,17], or care of others [18]. Patients with comorbid depression and chronic conditions such as diabetes and heart disease have been shown to have higher risks of complications [19,20], hospitalizations [21], mortality [22], and approximately two-fold higher annual health care costs compared to patients with chronic conditions alone [23,24].

Despite the high prevalence of psychiatric conditions among primary care patients and the maladaptive effects of these disorders on medical conditions and costs, there are major gaps in quality of care for these patients. Primary care providers in the United States are more than twice as likely to report problems with referral of patients with mental health problems to specialists than any other chronic condition [25]. Moreover, a large US study showed that only approximately 60% of patients referred by primary care doctors to mental health specialists actually followed through with the referral [26], and studies have shown that the mean number of appointments in those who do pursue a specialty mental health referral is two [27]. Thus, few patients who receive mental health care after primary care referral actually receive an adequate “dose” of mental health care. Most patients initiate mental

health care within the primary care system, but there are major gaps in the quality of mental health services provided in primary care [28].

Over the past two decades, data from the United States and other social democracies have shown improvement in recognition of depression and anxiety disorders by primary care physicians [29] as well as a large increase in the percentage of patients started on antidepressants [30], but there has been little change in the quality of treatment or outcomes of anxiety and depressive disorders [31–33]. Only approximately one in five primary care patients initiating antidepressant treatment receive three visits in the first 90 days of treatment as recommended in the NCQA Health Care Effectiveness Data and Information Set (HEDIS) depression performance measure [31]. Furthermore, the duration of treatment with newer and safer antidepressant medications has not changed from the tricyclic era—about 5–10% of patients prescribed an antidepressant in primary care never fill the first prescription, approximately 35% of patients started on an antidepressant never fill a second prescription, and less than half are still taking these medications at 6 months [32,33]. Less than 10% of primary care patients with depression receive a minimally adequate level of evidence-based psychotherapy [34]. As few as 20% of patients started on antidepressant medications in “usual” primary care show substantial clinical improvement [34,35]. Many patients referred to psychotherapy receive an insufficient number of visits and/or ineffective forms of psychotherapy [27,36], so that treatment response for this type of treatment is also as low as 20% [34,36]. Finally, poor quality of medical care in patients with mental illness may explain a significant portion of their excess mortality [37].

The large gaps in accurate recognition and treatment of common mental health disorders within primary care helped stimulate two decades of research into models of care that integrated mental health care services into primary care. These new models emphasized population-based care principles (i.e., taking care of all patients with specific mental conditions), measurement-based care so that there were metrics to follow to determine if the program was successful, and stepped care which permitted increasing intensity of care for patients with persistent symptoms [38]. The first study testing a new model of integrated mental health care, termed the “collaborative depression care model” was published in 1995 [39]. A 2013 meta-analysis of 78 randomized trials of collaborative versus usual care concluded that collaborative care improved quality of depression and anxiety care, as well as outcomes of depressive and anxiety disorders, for up to 2 years at either no greater costs, or in some populations, cost savings [40]. Collaborative care has become a robust example of a strategy to achieve the “triple aim” of improving health care experiences and clinical outcomes while reducing wasteful or unnecessary medical costs [38,40].

The key components of collaborative care include integration of an allied health professional (usually a social worker or nurse) into the primary care system in order to: enhance patient education; track depression and anxiety symptoms with a standard scales such as the Patient Health Questionnaire-9 (PHQ-9) [41] and the Generalized Anxiety Disorder-7 (GAD-7) [42]; and proactively track adherence to visits, medication, and side effects. Care managers have regular (usually weekly) meetings with a psychiatric consultant who makes recommendations for treatment adjustments (e.g., medication changes or psychotherapy) that care managers communicate to the primary care physician (PCP). In some collaborative care models, care managers are trained to provide patients with a choice of either starting treatment with a brief evidence-based psychotherapy, such as Problem-Solving Treatment in Primary Care, or initiating medication management for depression or anxiety [34]. Either choice of treatment can then be augmented when patients are not improving with an initial therapeutic modality. The psychiatric consultant in these models has the responsibility of systematically reviewing all patients in a care manager’s caseload who do not show clinical improvement and a key accountability role in working with care managers and PCPs to

ensure that patients do not remain on ineffective treatments. Care managers are tasked with reaching out to patients who have not been attending appointments or picking up prescriptions, with communicating recommendations for treatment adjustments to PCPs, and with keeping track of all active patients in a registry to make sure patients do not “fall through the cracks.”

Several states have implemented large-scale integrated care programs that build on the robust evidence-base for collaborative care. In the State of Washington, the Mental Health Integration Program, which is jointly sponsored by a non-profit health insurer (Community Health Plan of Washington) and Public Health of Seattle and King County, has partnered with the Advancing Integrated Mental Health Solutions (AIMS) Center at University of Washington to integrate collaborative care into over 140 community health clinics throughout the State, serving safety-net patients with medical and mental health needs [43]. A group of 20 consulting psychiatrists provide weekly caseload reviews of behavioral health care managers and PCPs in the participating primary care clinics, with quality of care and outcomes routinely tracked on a web-based electronic registry. Over 35,000 patients have received integrated behavioral health care in this program, and an early evaluation has demonstrated beneficial effects in terms of reducing homelessness and arrest rates, in addition to high rates of engagement and improved quality of mental health care. Clinical outcomes are tracked on both individual and aggregate bases, and a recent study shows that clinical outcomes can be further improved when 25% of the payment-for-services is tied to clinics achieving specific quality aims [43].

In Minnesota, the Depression Improvement Across Minnesota (DIAMOND) Program was developed to improve the quality of depression care and outcomes in over 80 primary care clinics throughout the State [44]. Six large commercial health insurers in the state agreed to provide case-rate payments for evidence-based collaborative depression care. These case rate payments cover evidence-based depression care management in primary care and systematic caseload reviews by designated consulting psychiatrists. Over 10,000 patients have been served by the DIAMOND program thus far, and early outcomes suggest that the majority of program participants show improvement in depression outcomes [44].

Many other large US health care systems, such as the Veterans Administration that cares for approximately 11 million Americans [45], and Kaiser Permanente [46] are also integrating collaborative depression care. Depression collaborative care efforts are also underway in several European countries, including England [47], Germany [48], and the Netherlands [49].

Much of the seminal research on collaborative care for depression was conducted before the widespread use of the concept of the PCMH. However, the core components of evidence-based collaborative care for depression described above are consistent with services provided by a Level 3 PCMH (e.g., care coordination functions, and registries to help track patient outcomes at an individual and panel level). A recent review of published literature on PCMH by Peikes and colleagues [50] concludes that few studies have actually demonstrated that Health Homes can achieve the “triple aim”: the goal of better patient care and outcomes at a lower cost. In this review, IMPACT, the largest study of collaborative care for depression to date, was featured as one of only six programs with published data suggesting that it can achieve these goals.

Accountable care

The concept of a PCMH is intended to improve the quality and outcomes of care at a clinic or micro-level. At a larger or macro-level, the notion of “Accountable Care” recognizes the importance of coordinating services across different providers and different levels of care to

achieve the goal of improving the quality and outcomes of care, while reducing overall health care costs [51]. A large proportion of health care costs are spent for hospitalizations for those with chronic medical disorders. For instance, approximately half of the total costs of patients with diabetes are hospital-related [52]. In fee-for-service care models, there was little incentive for systems of care to decrease rates of hospitalization. However, multiple new health reform policy changes are now providing both incentives for decreasing rates of hospitalization, as well as penalties for systems with higher rates of ambulatory care sensitive hospitalizations as well as re-hospitalizations within 30 days of an index hospitalization.

The Centers for Medicare and Medicaid Services (CMS) is funding multiple large demonstration projects of Accountable Care Organizations (ACOs) [53]. ACOs are built on the concept of primary care and specialty care systems and hospitals working closely together, including use of a single electronic record (EMR), and often a single governing unit. The use of EMRs to integrate inpatient and outpatient records, as well as other electronic technologies such as patient registries, is seen as key tool to improve continuity of care and decrease preventable hospitalizations. For ACOs to be most effective, it will likely be necessary to have robust primary care services that have been able to evolve into PCMHs [8]. ACOs will share potential cost-savings, based on reducing hospitalizations and other strategies, with the federal government and other payors [53].

As part of health reform and the ACA, CMS will penalize hospitals having higher percentages of patients with early readmissions (within 30 days) for specific conditions (such as pneumonia, myocardial infarction, and congestive heart failure), as well as hospitals that have higher percentages of Ambulatory Care Sensitive Hospitalizations (ACSHs). ACSHs have been defined as diagnoses that should not require inpatient treatment if timely and appropriate ambulatory care was provided, such as complications of diabetes [54]. Hospitals with higher percentages of patients with early readmission or ACSHs will receive lower Medicare payment rates for all patients.

For these new initiatives to be optimally successful, it will be essential for health care systems to integrate evidence-based mental health treatment models, especially for patients with comorbid mental health disorders who are disproportionately represented among patients with frequent and preventable hospitalizations.

The patients with greatest risk for hospitalization have multi-morbidity, defined as having at least two chronic conditions—approximately one-third of Medicare beneficiaries age 65–69 have three or more conditions [55]. In Scotland, a recent study of over 1.75 million adults registered in over 300 medical practices found that about one-quarter of mixed-aged adults had two or more chronic conditions [56]. Multi-morbidity is associated with a higher number of prescriptions [57,58], poorer adherence to self-care for chronic conditions [59,60], greater decline in functioning and quality of life [61,62], as well as a higher risk of hospitalization and increased length of hospitalization [63,64], leading to higher medical costs [55]. Approximately 65% of the total health care spending in the United States is directed toward 25% of people with two or more chronic conditions [55].

The above large Scottish study found that the risk of having a co-morbid mental health condition increased as the number of chronic conditions increased [56]. Compared to patients without chronic conditions, patients with five or more chronic conditions had over a six-fold increased risk of a psychiatric disorder compared to an approximately two-fold higher risk for those with one chronic condition [56]. A recent study found that in 180,000 adult primary care patients, having one or more mental health disorders increased the risk by approximately two-fold of a potentially preventable medical hospitalization [65]. In this

study, approximately 24% of primary care patients had one or more mental health disorders, but these patients accounted for approximately 45% of potentially preventable, unplanned hospital admissions [65]. The most common psychiatric comorbidity is depression and patients with chronic conditions, such as diabetes or coronary heart disease, have two-fold higher rates of depression than other primary care populations [66]. Such patients with comorbid major depression and diabetes have been found to have increased rates of ambulatory care sensitive hospitalizations [21], emergency room visits and/or hospitalizations for serious hypoglycemic episodes [67], and intensive care unit hospitalizations (which cost at least two times more than a typical medical/surgical hospitalization) [68]. Patients with a medical/surgical hospitalization who screen positive for depression on the PHQ-9 have an almost two-fold higher risk of a 30-day re-hospitalization [69].

Three collaborative depression care trials have evaluated the cost-effectiveness of collaborative care compared to usual primary care for patients with comorbid depression and diabetes: compared to usual primary care, all three trials showed improvements in quality of depression care and depression outcomes, as well as two-year total health care cost-savings [70–72]. One of the three trials continued to follow the population for 5 years and showed that the cost-savings found in the first 2 years continued in each of the subsequent 3 years [73]. The Improving Mood-Promoting Access to Collaborative Treatment Trial (IMPACT) compared the cost-effectiveness of collaborative depression care compared to usual care in 1,800 aging patients, 65 years and older [74]. These patients had a mean of four chronic medical illnesses and approximately 65% had chronic pain, most commonly from osteoarthritis. The IMPACT intervention found significant improvements compared to usual care in quality of depression care, functioning, and quality of life [34]. IMPACT cost-effectiveness analyses found that the higher outpatient costs in intervention versus control patients in Year 1 were offset by cost-savings in Years 2–4 [74]. These research findings on savings related to collaborative care are consistent with published data from large integrated health care systems, including Kaiser Permanente [46] and Intermountain Healthcare [75] – which function like mature Accountable Care Organizations – that have implemented collaborative depression care programs and realized substantial cost savings associated with these programs.

All four trials described above focused on improving depression care in aging medically ill populations [70–72,74]. However, the most complex and expensive patients in medical systems often have comorbid psychiatric illness, multiple adverse health behaviors – such as poor diet, obesity, smoking, and poor adherence to disease-control medications – as well as poor control of chronic medical illnesses. The evidence from the three collaborative care depression trials in patients with comorbid depression and diabetes was that improving quality of depression care and depression outcomes alone did not lead to marked changes in self-care regimens or beneficial changes in glycemic control [70–72]. The poor self-care and resulting complications in patients with comorbid depression and diabetes can also precipitate or worsen depressive symptoms [76].

A new multi-condition collaborative care intervention was recently tested in patients with comorbid depression and poorly controlled diabetes and/or heart disease (i.e., having at least one parameter of disease-control well above guidelines, such as HbA1c of 8.5% or above, systolic blood pressure >140, or LDL cholesterol >130) [77]. This program trained medical nurses to enhance treatment of depression, diabetes, and coronary heart disease by improving adherence to self-care regimens, as well as timely increases in intensification of medication treatments for those with poor disease control. Nurses were supervised weekly by both a primary care doctor and psychiatrist who recommended changes in medication that nurses communicated to the patient's primary care physician. Compared to usual care,

the TEAMcare multi-condition intervention improved depression, glycemic control, blood pressure, and LDL cholesterol outcomes, improved functioning and quality of life, and was associated with a reduction in total outpatient medical costs over a 24-month period [77,78]. Because the TEAMcare intervention helps with population-based quality of improvement for two medical illnesses and one behavioral illness, it has received a great deal of interest from health care systems that are integrating key components of the patient centered medical home. Implementing the TEAMcare intervention will help these systems receive NCQA accreditation for a Level 3 medical home. As described above, some states and health insurers are starting to provide more reimbursement per primary care visit for systems that reach this level of accreditation. Recognizing the importance of systematic improvement of care for patients with depression and comorbid medical disorders, the Center for Medicare and Medicaid Innovation Center recently awarded a multi-year grant to the Institute for Clinical Systems Improvement (ICSI) to work with eight organizations in seven states to implement a multi-condition care management program in 8,000 patients which includes core components of the TEAMcare model [77].

A major emphasis of health reform efforts is aimed at reducing 30-day re-admissions after an index hospitalization, as well as reducing ambulatory care sensitive hospitalizations. The fact that Medicare payments will be reduced for hospitals with higher percentages of patients with these types of hospitalizations is a major incentive to develop new systematic approaches to care. Several randomized trials have developed new health services approaches that have been shown to have modest effects on reducing re-hospitalization [79,80]. These interventions have usually involved a care manager visiting the patient on the last few days of hospitalization to review medication changes, ensure there is a timely follow-up visit with their primary care physician or specialist, and in some studies, arrange a home visit to assess home safety and support. Most of these studies have not screened for mental illness or cognitive impairment, and none have provided evidence-based mental health treatment [79–81]. As reviewed above, mental health conditions in general, and depression specifically, have been shown to be predictors of early re-hospitalization [69] and ambulatory care sensitive admissions [21,65]. Also, patients with more severe mental illness often receive poor quality of medical care [31], have poor adherence to self-care regimens [16], and inadequate preventive care [37,82]. Physicians with psychosomatic training and other mental health professionals have an opportunity to work with hospital systems to ensure adequate pre-discharge mental health screening of medical/surgical patients and to facilitate connection of those who screen positive to evidence-based mental health treatments integrated into primary care.

Hospital systems in the United States are also concerned with reducing lengths of stay and costs for “sitters” for high-risk patients. One of the major predictors for increased length of stay is delirium [83,84], and many consultation psychiatrists are helping hospital systems develop systematic delirium screening as part of the role of nurses when they measure patient vitals. Early recognition and treatment of delirium could potentially shorten stays of these patients and prevent hospital accidents like falls, as well as lead to lower costs for sitters.

Conclusion

Health care reform in the United States as well as in other social democracies is providing exciting opportunities for mental health services researchers and clinicians to help integrate evidence-based mental health programs into these efforts. There is a large body of research demonstrating the cost-effectiveness of integrating collaborative care models, particularly in patients with comorbid medical and psychiatric illness. The main issue that has hindered widespread implementation of these new models of care is how systems can pay for them,

since it takes an initial investment in time and money to develop changes in the way care is delivered. Also, in the United States, the cost-savings often benefit the health insurer, not the primary care system and hospital system. The combination of financial incentives to implement evidence-based models to improve care, and disincentives for key markers of poor care, such as preventable hospitalizations, are helping stimulate such changes in care.

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