The Hidden Value of Behavioral Health

JOHN SANTOPIETRO, MD, DFAPA

As healthcare in the United States—an enormous super-system not overly fond of abrupt turns—prepares for the 90-degree lurch that is healthcare reform, it has found an unlikely ally: behavioral health.

The healthcare market in the United States now comprises over $3 trillion per year—that is more than the gross domestic product of France. It is well accepted that, for all the resources we expend, our system doesn't deliver the outcomes we would expect by almost all common measures: quality, safety, efficiency.[1] In current parlance, our healthcare machinery doesn't produce the value we need to keep our population and economy healthy and to make it worth that kind of investment. This is the basic principle driving healthcare reform: value; we need to transform from a volume-based system to a value-based one. In the value-based world, we use the "Triple Aim" as a guide: better care, better health of the population, and lower cost.[2] As payments align evermore to the goal, what matters isn't the number of diagnostic tests, surgeries, or outpatient visits you perform in a day, what matters is the response to this question: What value did those interventions produce, and at what cost? In this new world, where cost and population health matter just as much and, eventually, more than keeping hospital beds full, behavioral health has found itself on radar screens it never expected before.

In the volume world, behavioral health never added much to the bottom line given its labor-intense and time-dependent nature and its ever-shrinking reimbursement rates. In the value world, however, behavioral healthcare—when done well—is like gold. Why? Not because it generates revenue on its own side of the ledger, but because it reduces cost on the medical side, and does so significantly. This has been well known for decades. An extensive analysis by Milliman in 2014 confirmed it yet again, finding that a comorbid mental health condition doubles or triples the total cost of care, with most of that cost occurring in medical hospitalizations and emergency department (ED) visits.[3] They suggest—conservatively, in my view—that integrating behavioral health and medical care would save $26 billion to $48 billion annually. Given that a modest investment in behavioral health infrastructure goes a long way (the positive side of its aforementioned nature as a system based on person-to-person time rather than procedures and equipment), and given that we have been spending significantly less on behavioral health as a percentage of overall healthcare over the last several decades,[4] logic would suggest that now is the time to start investing in behavioral health if we want better health and lower cost.

Case Study

My story would end there were it not for the fact that, over the last 3 years, I have had a front-row seat to watch what happens when a large health system makes exactly that decision. Carolinas HealthCare System (CHS) is a large, nonprofit, integrated delivery network with 39 hospitals and 900 care locations in the Carolinas, serving well over 2 million patients a year. Five or 6 years ago, CHS leaders began looking seriously into the subject of behavioral health and the value it could bring as healthcare transforms. Three years ago, they created a service line of behavioral health in order to have a corporate-level platform from which to assess the needs of the population and system, and

from which to develop strategy in order to respond to these needs. I have been lucky to lead this service line, since its inception, in a dyad leadership pair with an administrative counterpart, Martha Whitecotton. What we have been able to achieve in 3 years is living proof of the value of behavioral health expansion within a large system. In just 3 years, our service line has driven 4 major projects.

Psychiatric Bed Capacity

The first, and most visible, was building a new state-of-the-art 66-bed psychiatric hospital. Although inpatient treatment is not the goal in behavioral health, it is a critical part of the continuum of care. The dearth of beds nationally has driven patients who are in crisis into medical EDs in record numbers. The number of state psychiatric beds in the United States has declined precipitously from over 550,000 in 1955 to less than 45,000 in 2010, leaving us with access to psychiatric beds per capita at comparable levels to what we had in 1850, as in before the Civil War.[5] In North Carolina, with one of the lowest per-capita psychiatric bed ratios in the country, we have almost twice the national average of psychiatric patients stuck in medical EDs.[6] The 66 new beds bring us to over 400 in our system are an important step in the right direction.

Mental Health First Aid

The second major initiative has been to promote Mental Health First Aid, an 8-hour course similar to CPR, which teaches the basics on how to recognize and manage a psychiatric crisis. We have trained over 5000 individuals in the community, including teachers, clergy, athletic trainers, and law enforcement officers. In addition to providing important tools, this is a public health literacy campaign that reduces the stigma associated with mental illness. The more stigma in a community, the fewer people access care and the more cases of untreated mental illness, which again results in driving down health and driving up suffering and cost.

Integration into Primary Care

The third initiative—the largest in scope—has been to integrate behavioral health into our 200 primary care offices, serving 800,000 patients, in order to intervene "upstream," where the barriers and acuity are low, and before things have reached a crisis point. We based our model on the well-proven IMPACT model, which was created and based out of the University of Washington AIMS Center.[7] We knew, however, that scaling this co-located model across 200 offices would be a challenge, so we deconstructed and then reconstructed the model into a "virtual team," which allowed our team to have more members, to be deployed across more primary care offices, and for each team member to be able to bring their full skill set to bear. They are located off-site and use the phone, video, and the electronic health record (EHR) to communicate with the primary care team and the patient. Whereas in the IMPACT model there is a somewhat generic, co-located "behavioral health provider" performing multiple tasks, such as assessment, diagnosis, navigation, communication, and registry-management, we were able to have distinct team members devoted to each of those functions. In almost 2 years, our team of 20—comprised of social workers, coaches, therapists, a pharmacist, and a psychiatrist—has treated 5000 patients in 50 primary care practices, and we have our first 6-month cut of data. It is a pre-/post cohort, and therefore not randomized or controlled, but we wanted an early look, and the results are encouraging. The mental health scores are improving significantly (for depression and anxiety), as are metrics like glycosylated hemoglobin and cholesterol—all with statistical significance. And, although 6 months is early to get a thorough assessment of utilization, this glimpse suggests that while outpatient visits are up modestly in this group, inpatient utilization is down, which is, of course, where most of the cost lies.

Taking on the ED Boarding Crisis

The fourth initiative of the behavioral health service line was a spin-off of this virtual primary care team that we deployed to help our medical EDs that are backed up with psychiatric patients. In North Carolina, the average length of stay for patients presenting to medical EDs needing psychiatric hospitalizations approaches 2 days; in our own system, it was nearing 40 hours. The boarding of psychiatric patients in EDs has become a national crisis according to many, including the Joint Commission.[8] We took a smaller version of the virtual behavioral health team (ie, a nurse, bed manager, social worker, and psychiatrist) and deployed them to 20 of our Charlotte-area medical EDs. That team now feels ownership for the psychiatric patients presenting to the EDs, and gets involved as soon as possible in their care. The behavioral health team communicates with both the medical team and the patient, and uses tele-psychiatry if needed.

Importantly, the ED physicians have agreed to allow our psychiatrists to enter orders remotely in the EHR, which saves time to initiate care. Additionally, we use a company that has expertise in safely transporting patients who need psychiatric hospitalization so that we don't have to rely solely on law enforcement transport, which had been the case previously. We now do 300 transports a month with this private vendor, in addition to the 300 a month still done by law enforcement. We perform 900 tele-psychiatry encounters a month; the result being a 50% reduction in the length of stay for psychiatric patients in those 20 EDs and a savings of over $1 million in sitter costs alone. And, most importantly, the care and experience of care is much better for those patients who come to the ED in psychiatric crisis because they have no other place to go.

Conclusions

Challenges remain, of course, and we are still at the beginning of a larger journey. We struggle to scale these programs fast enough to meet the full demand across our geography. Nevertheless, after 3 years, our experience is living proof of the power of behavioral health to drive value in this new healthcare world.

Author Affiliation: Carolinas HealthCare System, Charlotte, NC.
Source of Funding: None.
Author Disclosures: The author reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.
Authorship Information: Concept and design; acquisition of data; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content.
Send Correspondence to: John Santopietro, MD, DFAPA, Chief Clinical Officer, Behavioral Health, Carolinas HealthCare System, 720 East Morehead St, Ste 300, Charlotte, NC 28202. E-mail: john.santopietro@carolinashealthcare.org.

REFERENCES

1. Davis K, Stremikis K, Squires D, Schoen C. Mirror, mirror on the wall, 2014 update: how the U.S. health care system compares internationally. The Commonwealth Fund website. http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror. Published June 16, 2014. Accessed May 2016.
2. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Aff (Millwood). 2008;27(3):759-769. doi: 10.1377/hlthaff.27.3.759.
3. Milliman report summary: economic impact of integrated medical-behavioral healthcare—implications for psychiatry. Milliman report summary. Alliance of Community Health Plans website. http://www.achp.org/wp-content/uploads/milliman-report-summary-20141.pdf. Published April 2014. Accessed May 2016.
4. Frank RG, Glied SA. *Better But Not Well: Mental Health Policy in the United States Since 1950*. Baltimore, MD: Johns Hopkins University Press; 2006.
5. Torrey EF, Fuller DA, Geller J, Jacobs C, Ragosta K. No room at the inn: trends and consequences of closing public psychiatric hospitals—2005-2010. Treatment Advocacy Center website. http://www.tacreports.org/storage/documents/no_room_at_the_inn-2012.pdf. Published July 19, 2012. Accessed May 2016.
6. Centers for Disease Control and Prevention. Emergency department visits by patients with mental health disorders—North Carolina, 2008-2010. *MMWR Morb Mortal Wkly Rep*. 2013;62(23):469-472.
7. IMPACT: Improving Mood—Promoting Access to Collaborative Treatment. AIMS Center website. http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/. Accessed May 2016.
8. Alleviating ED boarding of psychiatric patients. The Joint Commission website. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.PDF. Published December 2015. Accessed May 2016.