Testimony Presented to the Pennsylvania Senate Public Health and Welfare Committee

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Introduction

Chair Vance, thank you for the opportunity to address the Senate Public Health and Welfare Committee. My name is Paul Kettlewell, and I am the Chief of Pediatric Psychology, for the Geisinger Health System. I have been in practice as a psychologist and worked in the Geisinger Health System for over 30 years. I serve as a program director, a clinical teacher, a researcher, and I provide pediatric psychology services to children, adolescents and their families.

The Geisinger Medical Center's Division of Psychiatry has a long history of working closely with county mental health providers and systems. We have an emergency department in which the majority of the patients experiencing mental health crises in our region come to be evaluated. I have personally worked for many years evaluating children and adolescents who present to our emergency department with mental health problems. It has been my responsibility to develop our system of care for those children and adolescents in crises and to appropriately engage family members when conducting those emergency evaluations and developing appropriate behavioral health services. It is through this lens that I would like to provide a broader context within which to consider the many issues that are associated with behavioral health care, including involuntary commitments.

Because of my experiences in directing a department and in personally providing care, I am acutely aware of the problems or limitations with our current behavioral health care delivery system and the need for changes. I would like to share with you the rationale for change in behavioral healthcare delivery, the response from the Geisinger Health System, the barriers to making changes, and ways your committee may be able to help.

Key Problems with the Behavioral Health Care Delivery System

The burden of behavioral health disorders in the United States is staggering, with estimates that approximately 1 in 17 adults and 1 in 9 children and adolescents suffer from some form of diagnosable mental illness. Many are not adequately identified, while many others do not receive care from behavioral health providers. The current behavioral health care delivery system fails patients and their families on multiple levels, and even though effective treatments exist for most behavioral health disorders, only about one third of affected patients actually receive these treatments. For children and adolescent in rural Pennsylvania the problem is even worse with only approximately one fifth of the children and adolescents in need receiving any type of

behavioral health services. The lack of behavioral health services for those in need contribute significantly to a range of social problems, cause significant impairment for those not receiving care, and are detrimental to quality of life across settings. These are problems that deserve our best efforts to improve the current behavioral health care delivery system. I appreciate being invited to discuss these issues with you because I know you all share the goal of finding ways to improve how mental health services are delivered in Pennsylvania.

What happens to those patients with behavioral health problems who do not get services from behavioral health specialists? Many of them turn to their primary care providers for behavioral health services. In fact, primary care physicians provide the majority of behavioral health services, but have neither sufficient time nor training for adequate treatment.

Integration of Behavioral Health Services with Primary Care

A particularly promising and innovative approach that addresses these failures is a health care is a model in which behavioral health providers are embedded or integrated in the primary care setting. These behavioral health providers collaborate with primary care physicians, are available daily to discuss patient care and serve patients on the same day as requested. This approach has the potential to improve outcome from both the patient and provider perspectives.

Encouraging research demonstrates improved clinical outcomes for patients, improved patient and provider satisfaction, cost savings and improved access to care. Our recently completed three (3) year project also demonstrated positive outcomes including significantly improved patient and provider satisfaction, a three-fold improvement in access to care, better quality of life, and cost reductions including reductions in prescriptions.

Primarily based on the positive broad outcomes and lessons learned from four years of implementing this integrated care model in both pediatric and adult primary care settings, we at the Geisinger Health System intend to expand this model throughout our community practice sites which include over 40 primary care settings in central and northeastern Pennsylvania. Several other healthcare systems in Pennsylvania are likewise expanding using this integrated care model.

Barriers to Expansion of This Integrated Care Model

I. <u>The Need for Changes in Mental Health Regulations</u>

When innovative approaches in health care delivery are developed, the regulatory policies previously developed to address key concerns in the "standard" healthcare delivery approach can inadvertently hamper innovation and interfere with or delay much needed services to patients. Such is the case with regulations that apply to this integrated care model and which we believe do not add value. In fact, these regulations, specifically for licensed outpatient mental health facilities, present unnecessary barriers to effective and efficient care and to the expansion of this integrated care model.

Unfortunately the regulations which guide this practice have not been modified for many years. The Mental Health and Mental Retardation Act of 1966 established the framework for practice.

The General Provisions Section 5200 regulations are the core for outpatient clinic practice. Some of these provisions continue to guide quality practice but other elements lead to inefficiency and actually create barriers to quality care.

For many years, the state Department of Public Welfare (DPW), now the Department of Human Services (DHS) representatives and providers have advocated for the review and revision of these regulations. Unfortunately this has been considered too time consuming or problematic to address. I would like to specify some regulations that are particularly problematic in the provision of integrated behavioral health care in primary care settings and present some recommendations which would diminish or eliminate these areas of difficulty. The most significant changes should be targeted at Provision 5200.31 which describes Treatment Planning. There are multiple elements within this provision that need to be modified.

<u>Recommendation 1: Remove the requirement that a psychiatrist must sign each treatment plan.</u>

Licensure laws within the State of Pennsylvania place treatment planning within the scope of practice of any licensed mental health professional.

It is my understanding that DHS convened a review committee which specifically discussed this issue. DHS reviewers were aware that due to patient volume and the lack of psychiatry time, the review of treatment plans by psychiatrists was cursory at best. Psychiatrists are not content experts in the area of treatment planning and are not required to meet each patient in treatment. Therefore this process is perfunctory, a significant misuse of a psychiatrist's time and places psychiatrists at some legal risk for the care of patients with whom they have had no significant role.

<u>Recommendation 2: Lengthen the treatment plan requirement from 15 to 30 days.</u>

Patients are often unable or unwilling to complete multiple appointments in a short time frame. Assessment activities can require multiple sessions. A plan of care or treatment plan is an important collaborative element between a patient and provider which need not be rushed.

<u>Recommendation 3: Eliminate the 120 day review. Treatment plans can be revised as needed</u>.

Reviewing treatment plans every 120 days to complete a documented review is also a misuse of time. A progress notes by definition is the progress of a patient towards treatment goals. This happens at each patient visit and need not be formally revisited every 120 days. If a clinician sees that the plan of care is not helpful, the treatment plan can be revised at any time. In the primary care setting, it is typical that a patient move in and out of treatment as symptoms wax and wane. The arbitrary 120 day requirement creates unnecessary paperwork and adds no value.

<u>Recommendation 4: Eliminate the requirement for discharge summaries in primary care settings.</u>

Discharge summaries are based in part on the assumption that patients will complete a well-organized course of care which will have a distinct ending. Inpatient care is an example of this type of treatment. This should be contrasted with the primary care physician model in which the patient comes in for care as needed and exits when a problem is resolved. There are times when chronic conditions require ongoing care. Discharge summaries are much less useful in this

model. With the advent of electronic medical records and sharing of records between systems with patient consent, the need for distinct discharge summaries are less important.

II. The Need to Encourage Public/Private Partnerships by Allowing Health Systems to Obtain Information about Medicaid Patients Including Claims Data

The integrated care model holds promise to reduce health care costs. Although there is some limited evidence of cost savings associated with this innovative model, more research is clearly needed to answer this question. One of the main problems which interferes with adequately evaluating questions associated with cost savings from this model is that it is often hard for health care administrators evaluating their programs and researchers to get financial data. Health insurers including government based insurance providers like Medicare and Medicaid are usually reluctant or refuse to share claims data. There may be legal or regulatory restrictions that prevent this data from being included in outcome research. Nevertheless, if we want to encourage innovation and ways to address the serious limitations of our current behavioral health care delivery system, we must encourage public/private partnerships, which need to include giving health care systems access to Medicaid data.

III. The Need for Some Change in How We Bill for Brief Consultations in Integrated Care

With this new model for health care delivery comes some change and expansion of the role of behavioral health providers in the primary care setting. One of the key roles is that behavioral health providers conduct brief consultations which involve discussions with primary care providers and initial discussions with patients on the same day as the primary care appointment. This consultation adds value for patients and primary care providers because it helps primary care physicians be more efficient in their practices (able to use a behavioral health provider to discuss complex behavioral health issues with patients) and it increases use of behavioral health services by efficiently establishing relationships with patients. Yet, this activity is not reimbursable under current CPT billing procedures. However, in Federally Qualified Healthcare Centers (FQHCs) this activity is reimbursed under a new "t code". Use of this "t code" establishes that this activity adds value. We would like to request your assistance in using this "t code" for integrated care activity in non-FQHC integrated care sites.

IV. The Need to Eliminate Behavioral Health Insurance Carve-Outs

The arbitrary policies that force health insurance for behavioral health problems to be "carved-out" from medical insurance are conceptually defective and interfere with innovations in health care delivery, efforts to save money, and the provision of good care to patients. There are many examples of behavioral health/medical disorders that demonstrate the illogical approach to dividing patient care between medical disorders (body) and behavioral disorders (mind). Does a child with ADHD have a medical condition (that responds to stimulant medication and often prescribed by a pediatrician) or a behavioral health condition (that also benefits from behavioral treatment provided by a psychologist)? Does an adolescent who is obese have a medical condition (with all this increased risk for multiple medical problems) or a behavior condition (that is helped with behavioral interventions)? Frankly, behavioral health "carve-outs" represent

de facto discrimination against our citizens with behavioral health problems and is one of the reasons for those with behavioral health problems being so vastly underserved. It is time to end this arbitrary, illogical and discriminatory policy. The Commonwealth of Pennsylvania needs to consider how best to assure integration of care, especially for patients who receive Medicaid.

Closing

I sincerely thank you for the opportunity to address this committee. I and my colleagues from Geisinger Health System will continue to collaborate with the Hospital & Healthsystem Association of Pennsylvania (HAP), this committee and other stakeholders, including the patients we serve, to address these concerns. Important changes are possible and these changes will improve the care we provide our citizens with behavioral health problems. I look forward to addressing your questions from a pediatric perspective.

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