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Silo-Busting: The Texas Effort to Make Mental Health Care Mainstream

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Silo-Busting: The Texas Effort to Make Mental Health Care Mainstream

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Dedication

To Dan who has walked with me, side by side, always encouraging me to "get to the bottom of things." To my family. To Tracy Dahlby and the University of Texas at Austin Journalism School who gave me the skills and ethics needed to pursue stories that matter. To Matthew Crowley. And to everyone, anyone, suffering from any and all mental health issues: Your struggle matters and you are never alone.

Abstract

Silo-Busting: The Texas Effort to Make Mental Health Care Mainstream

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Amid the ongoing political debate over health care, a revolutionary approach to the actual practice of medicine is quietly taking root nationwide, and especially in Texas. So-called "integrated care," in which collaborative teams treat patients' mental and physical health together, is becoming particularly popular despite Texas' poor health care track record. Integrated care breaks down the traditional "silos" that have kept mental and physical health care separate throughout the years, and claims to make patients healthier for less money. But Texas will have to overcome several logistical, training and financial hurdles before it can become the norm.

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Kerstin Taylor's studio apartment is a testament to her resilience despite decades of struggle with her mental health. It's in a mid-rise building off a major thoroughfare in south Austin, and is filled with her grandmother's paintings, Christian crosses, photos and stuffed animals. When her case managers come by to check in on her, Taylor shows off her stuffed animals in particular.

“They all have names and that has to do with, truly, the family I never had, my broken family,” Taylor said during an interview at her home this fall.

Her home is evidence of a life rebuilt. Taylor, 52, came from an abusive family that didn’t provider her with the foundation for a healthy, stable life. When she came to Austin from Illinois in the 1990s, Taylor was suffering from alcohol and drug addiction, which compounded her existing bipolar and obsessive-compulsive disorders. For years, Taylor periodically sought mental health treatment, but her recovery never lasted long.

What was missing, she thinks, was support that addressed the range of her challenges and deficits. In part because of her upbringing, Taylor hadn’t built habits like getting proper nutrition, rest and exercise. She hadn't developed healthy interpersonal skills either. She also wasn't taking care of her physical health, which is common for people in her situation — data show that people with severe mental health issues can die between 10 and 28 years earlier than the general population. Taylor didn’t see a doctor for many years, especially when she was an active addict.

“I was lost,” she said, her voice quavering. “I felt like a lost cause.”

Things turned around for Taylor when Integral Care, Texas’ fourth-largest community mental health center, started offering integrated health services. Integrated care brings mental and physical health care together, and providers collaborate on patient treatment. This meant that Integral Care treated Taylor not only with medication, but enrolled her in a chronic disease management program, trauma therapy, an addiction program and regular visits with a primary care doctor.

“It has built my self-esteem. It's helped me communicate better with personal relationships, with my mother, with my significant other, with my neighbors. It has really built me up to be a better woman,” she said.

The integrated health care Taylor credits for her recovery is just starting to take root in Texas, and while many say it's the future of health care in general, progress is slow and there are many obstacles. The climate for mental health care in Texas is inhospitable. Eighty percent of counties don't have enough mental health professionals to care for the approximately 3.8 million people in need, according to data from the Texas Health and Human Services Commission. And Texas has the highest rate of uninsured people in the nation at over 16 percent. Despite these shortcomings, many practitioners see integrated care as necessary for their patients’ health, and an efficient way to do business.

Integration is also a trend nationwide, but it has taken hold in varying degrees depending on the state. Some states are building integrated practices in the public sector, which even includes some Veterans Affairs and Department of Defense clinics. In others, integration has sprung up more through the private sector. Some cite Cherokee Health Systems in Tennessee and Kaiser Permanente in California as gold standards. But some states lag behind. Since 2009, Texas has only had five integrated health pilot projects sponsored by the Substance Abuse and Mental Health Services Administration. That's compared to the 41 projects in New York and California combined.

In Texas, integrated health care will require doing away with the traditional mental and physical "silos" that have operated independently for decades. As a result, clinics will have to hire new types of health care practitioners, and universities will need to develop team-based training programs. There also will need to be broader buy-in from insurance companies, and a more flexible reimbursement system that does away with piecemeal billing.

But making these changes is like trying to move the gears of a very large, rusty bicycle. The system is stubborn and slow to shift. Integrated care is growing, especially in public clinics, but many are already underfunded by state and federal budgets. And while recent legislation sought to benefit Texans' mental health, the political will to expand Medicaid is limited, putting further strain on the system. Also, many practicing doctors and mental health professionals aren't equipped or willing to work collaboratively. And insurers need

proof that integration is a solid investment; it's a hard thing to prove because the needs of regional health care markets can differ greatly.

A confluence of social and political factors surrounds the push for integration. The World Federation for Mental Health called depression a "global crisis" in a 2012 paper, and University of Texas Southwestern Psychiatrist Dr. Madhukar Trivedi echoed that, saying at a conference in Austin this fall that America suffers from a depression epidemic. America's other mental health crisis, with opioids, is causing 91 overdoses per day, according to the Centers for Disease Control and Prevention, and has forced Americans to recon with the result of poor access to mental health care. But the Affordable Care Act is perhaps the most crucial factor. It created a logistical and financial framework so that integrated practices can operate more easily.

But the political debate over the ACA has put some of its policies in limbo, which could have an effect on integration. In the House health care bill last spring, lawmakers in Washington sought to fully repeal the ACA, which included doing away with its essential health benefits — one of them ensuring equal access to mental health services and addiction treatment. Texas Republican Rep. Joe Barton tweeted at the time, "It's time to repeal Obamacare and put in place a new plan that lowers costs."

It's also a pivotal time in mental health history. Keith Humphreys, professor and director of Mental Health Policy at Stanford's Department of Psychiatry and Behavioral Sciences, says for centuries, Europeans locked up people with mental health issues. "They were

seen…as occupied by spirits or being witches," Humphreys said in a phone interview. In America, mental health has always been on the fringes of the health care system. But social media campaigns like #stigmafree show that the culture is starting to catch up with the decades of research showing the importance of treating mental and physical health equally. The passage of the ACA in 2010 was the culmination of that work.

Neftali Serrano, executive director for the Collaborative Family Healthcare Association, or CFHA, says the concept, which started in the '90s, is just now being viewed at a salve for some of our nation's nagging health care dilemmas. In an interview at the CFHA conference in Houston this fall, Serrano summed it up this way: "You need to consider the unique interplay of mind and body, who we are, our families, genetics, physical health status, chronic illnesses. If you don't put those together, you end up with the inefficiency we have in our health system today."

Integration is well underway at a large community heath care clinic in north Austin. This summer, Pediatrician Tracy Lama-Briseño traversed CommUnity Care's long, narrow hallways tending to her young patients. Dr. Lama, as she prefers to be called, has been at CommUnity Care for six years and says she always wanted to work with low-income families. "From the get-go, it's the population I was drawn toward," she said as she talked in one of the clinic's small, sunlit offices.

Since CommUnity Care started offering integrated mental health services through its E-Merge program, Dr. Lama has been collaborating daily with therapists and social

workers. She says a surprising number of her patients have mental health issues, ranging from grief about a recent death in the family, to anxiety or depression from family troubles. Either way, she has mental health providers to bring into the treatment room immediately.

The State of Texas has pushed for public clinics to integrate, and while Dr. Lama thinks it's a good idea, it can cause stress. “I may have a patient that comes in for complaint of an earache, for example, and then it turns into a completely different type of visit,” she said. With full-time mental health professionals on staff, Dr. Lama isn’t on her own, but she says even more social workers would help. CommUnity Care is more integrated than some clinics elsewhere in the state, however, partly because it's in a wealthy city with a sophisticated mental health care system.

But other clinics are finding integration harder. Texoma is a small public mental health clinic in Sherman, a town of about 38,000 people that has become something of a destination for care in the region because of its proximity to Oklahoma. Texoma CEO Daniel Thompson said in a phone interview last spring that the need for care has “exploded.”

“Our catchment area bumps right up to southern Oklahoma, and the mental health system in Oklahoma was financially devastated. ...We have a lot of folks that come across the border for services,” Thompson said.

Thompson says integrating his clinic would be a huge undertaking. Texoma would need a full-time primary care doctor but Thompson can only offer his clients a referral to one outside the clinic. Texoma would also need a new electronic medical records and billing system if it wants to add physical health care. That's because mental and physical health care are still administrated separately. Thompson likens trying to pay for all this to "squeezing blood out of a turnip" — it's costly and the clinic is already cash-strapped.

A clinic at the University of Texas Rio Grande Valley School of Medicine has found an intermediate option that makes integration possible, even in a region with high poverty rates. There, behavioral health consultants, or BHCs — who are psychologists — work alongside primary care physicians to handle patients' mental health concerns. This takes the burden off physicians who aren't specially trained in mental health care. BHCs are essentially a new profession. Deepu George, a faculty member of the medical school, says unlike private-practice psychologists, BHCs closely coordinate their work with that of the physician.

"A typical therapist would see five patients, where a BHC would see seven to 14 patients [in a day]. So the primary care physician is able to think about what they can use the BHC for and reliably bring them in every time they see [mental health] issues," George said during a presentation at a conference in Austin this fall.

George, neatly dressed with a striped orange tie, talked about a 59-year-old Hispanic man who served as a case study for the clinic. The man had complained of fatigue and abdominal pain, and was suffering from diabetes and alcohol abuse. He was also haunted by thoughts of his son's death several years ago, which made it hard to care for himself. In a session with the BHC, George said they determined that grief was having a significant impact on the man's overall health. Not only was he crying a lot, he wouldn't take his medication or leave his house. Instead of drugs, the BHC suggested small behavioral changes, like watering the plants he'd been neglecting.

“We relied on the idea of what is the smallest unit of change that can have a domino effect on other areas of their life?” George said.

Dr. Naomi Davis, the patient's primary care doctor who was also helping George give the presentation, says having the BHC there gives her more options. Rather than simply giving patients “good old SSRIs” when they talk about distress, she can have them consult with the BHC to explore other options.

But a BHC is a financial investment for a clinic. And not every psychologist is equipped to do this work. Serrano of the CFHA says they need special training, and the workforce that would be needed to handle widespread integration is still being built. Today in Texas, there are practicing BHCs, but for an integrated system to be viable, there needs to be more than the handful of graduates doctoral programs produce each year.

“This is not just about plopping a mental health professional in a primary care setting,” he said. “It takes...a certain kind of behavioral health professional, and well-trained physicians and nurse practitioners and P.A.s to do this work well.”

Texoma already has the mental health care side covered but needs primary care doctors in order to make it truly integrated. Their high salaries makes that impossible right now, but Thompson does have an advanced practice registered nurse on staff who helps fill the gaps. In the mean time, Thompson is looking forward to the eventuality of providing complete physical health care at his clinic for his clients who also have mental health disorders. They're mostly indigent and prone to chronic disease. He hopes one day, Texoma will be a one-stop-shop for all their care.

“I believe the anticipated federal and state changes will dictate we move in this direction, and regardless [of] any directives, it is simply the right thing to do,” Thompson said in an email.

In some cases, the skeptics of integration are the doctors and psychologists themselves. Dr. William Streusand is a child psychiatrist whose private practice sits in the leafy, rolling hills of west Austin. His practice is semi-integrated with a nurse practitioner and a licensed professional counselor, but no primary care doctor. Streusand is a champion of integrated care, albeit with some conditions. He helped establish the embedded mental health care program at People’s Community Clinic in Austin, and he's trained various physicians to work in collaborative settings.

Collaboration is an important part of his work, but hierarchy still plays a role. After years of education, training and practice, he's protective of the role psychiatrists play in shaping mental health care, and was troubled last spring when psychologists were lobbying the legislature for the ability to write prescriptions. They argued it would take pressure off of Texas' stretched pool of psychiatrists, but Streusand opposed it.

“It's a threat to psychiatrists,” he said in an interview at his office last spring. Psychiatrists would be “giving away our power.” Plus, he believes that psychologists don't have the same understanding of the body and medicine that medical doctors do.

Talking to Streusand is like finding a rare bird in the wild. He's one of approximately 228 child psychiatrists in Texas, according to 2015 state data analyzed by the Texas Medical Association. Texas ranks among the states with the highest need, having only eight psychiatrists for every 100,000 children. That rarity gives him clout and the ability to be picky about his colleagues. He says his psychiatric nurse, for example, is “very sophisticated,” but she stands out among other nurses with whom he wouldn't be willing to work.

Most patients want their physicians to have high standards. But underneath Streusand's argument lies longstanding cultural problems within the medical system that could pose problems for integration. Collaboration is essential for integration to work, but it also requires practitioners with various levels of education to trust one another's expertise.

Recent battles among various professional guilds show how important hierarchy still is in health care. Earlier this year, the Texas Association for Marriage and Family Therapy, which represents mental health practitioners with master's degrees, won a seven-year legal battle with the Texas Medical Association, which represents medical doctors. It culminated in a ruling by the Texas Supreme Court that the therapists are allowed to diagnose patients — something the medical association was fighting. And during the legislative session this spring, psychologists (who have doctorates) were lobbying to prevent the various master's level mental health professions from being overrepresented in a proposed executive council for a statewide behavioral health agency.

Celeste Riley, a private-practice psychologist in Bryan, was one of those psychologists lobbying for the Texas Psychological Association at the Capitol. When we met, she was sitting alone in the cafeteria going over her talking points. Riley has been practicing for 10 years and seemed worried that day that people with less education could erode her profession's standards. The proposed bill never passed but if it had, psychologists would have been outnumbered in the council 5-1 by master's-level professions.

"It would be like dentists being governed by dental hygienists, in essence," Riley said. "I don't want to have to address quality of care issues in five years."

But the University of Texas at Austin's Dell Medical School is counting on collaboration between various health care practitioners to be the norm one day—regardless of the

current strife. It's implementing a new integrated training program for medical students, thanks to a recent $440,000 grant from the Hogg Foundation for Mental Health. The grant will help Dell Medical develop a team-based learning curriculum. According to a press release from the foundation, it will also teach future doctors the "best practices of integrating mental health care."

Bill Tierney, chair of Dell Medical's Population Health Department, says this type of training is long overdue. He says for years, even he fell victim to the pitfalls of working on his own as a family doctor and not "talking" to the other professions. "When I had no mental health support within the clinic, I did tend to treat people with medications because that's what I had," he said in an interview at the medical school last spring.

UT-Austin is also training other professionals to be pioneers in health care integration. The School of Social Work's integration program, which started in 2013, has graduated 18 students. Fifteen of those graduates have stayed to work in Texas. The College of Education has been training psychology doctoral students to work in integrated health care since 2010, and has graduated 24 psychologists so far, with more on the way in 2019. These students are essentially forming a new professional group because surveys show a majority of psychologists rarely collaborate in an integrated setting. In a 2015 survey from the American Psychological Association, over a quarter said they never collaborate at all.

Practicing physicians aren't much more collaborative, but the new program at Dell Medical School could help change that. A 2016 survey from the Physicians Foundation found that only 30 percent of physicians work in patient-centered medical homes. This is an industry term describing an integrated practice that uses a team-based model to care for the mental and physical health of its patients. Thirty-five Texas health care organizations, including Austin's CommUnity Care and People's Community Clinic, have this designation. Rick Ybarra, program manager at the Hogg Foundation, says the grant it gave Dell Medical could be a "game changer," especially because it will train doctors to work with addiction specialists, in addition to other non-physician mental health professionals.

The up-and-coming psychologists I met at the CFHA conference are part of a new wave of mental health professionals energized by integrated care. Part of that comes from the fact that integrated care in Texas right now is primarily focused on underserved populations. The social welfare element seems to be driving these young psychologists because they're able to reach people where care is most needed; a private practice doesn't necessarily afford that same opportunity.

Julie Heier is one of those psychologists, and was presenting a research poster with three of her colleagues at the conference. She had a welcoming smile and inquisitive demeanor but turned serious when we started talking about health care disparities. She says the clinics she's been training in are essential for people who would otherwise go without

mental health care. In Austin, that means people pushed outside the city into areas with limited access to services.

“Austin's developing so much and pushing out marginalized populations, and this is what provides their care,” Heier said.

She says integrated clinics are changing things. They flip the private-practice model on its head, she says, and they also care for the needs of patients in areas with limited mental health resources. Her training will equip her to work in an integrated practice one day, but it's her empathy that seemed to drive her more than anything.

Even with a solid workforce, one of the primary challenges to integrated care is money. Seventeen-year-old Marty, who doesn’t identify with a specific gender, has been hospitalized in Texas for mental health reasons several times. Marty is about to finish high school and asked to be identified by first name only for fear of potential discrimination in future workplaces. When Marty’s mental health crisis began, integrated care had already become a fairly common practice. As a result, Marty was able to see an equestrian therapist, an art therapist and a dietician, in addition to requisite psychiatrists, social workers and therapists. Marty's mom Gail says these services seemed frivolous at first, but when combined with the standard psychiatric care, they’ve helped keep Marty out of the hospital — which is expensive. Marty says the services have been a lifesaver.

“I literally jumped with joy because that made things so much better. ... It was such a great way to ease me out of the hospitalizations,” Marty said while sitting on the family’s living room couch this past summer. It was a sweltering day but Marty was wearing pants and a sweatshirt.

The problem is that these services aren’t readily available. State funding is limited and Gail says most kids don't reach eligibility until after several hospitalizations. Marty was on a waitlist for almost a year. Experts say it’s actually cheaper and more effective to pay for integrated services than to hospitalize someone, but to make those services available to more people, insurance companies will have to more fully buy into the model. As of now, this is only happening piecemeal.

On the one hand, insurers are integration's biggest supporters. In a 2016 special company report, Anthem, one of America’s largest health insurance companies with over $84 billion in annual revenue, said avoiding it would be a “missed opportunity” for detecting chronic conditions, and called integration a “strategy for reducing costs while improving outcomes.” On the other hand, Anthem and others are vague on the details. It's not clear how much any insurance company is invested in integration, and there’s no comprehensive list of which companies are integrating where.

Anthem Vice President Charles Gross touts how Anthem has embraced integrated care. In a phone interview this fall, Gross described how Anthem helped one client with mental and physical health problems get back on track through integrated services. But Gross

was only able to provide anecdotes. When pressed, neither he nor his organization would provide specific data or dollar amounts about Anthem's integrated programs.

The consensus among over a dozen mental health care providers interviewed for this story — and a handful of physicians — is that a lack of proper financing is a major factor slowing the pace of integration, and that insurers play a role in that. But Dr. Ernest Buck, chief medical officer for Driscoll Health Plan in south Texas, says it's not always the insurers who are getting in the way. His health plan covers people in a 26,000-square-mile region from south of San Antonio all the way to the southern tip of Texas in Brownsville. It consists of semi-urban areas like Corpus Christi, but also "lots of really small towns in between," Buck said in a phone interview this fall.

Buck says it's not insurers like him holding back integration in his area; it's the clinics that are reluctant to change their business model. "It's hard to start a new model where a physician's practice could be put at risk," Buck said. "People that are happy with the status quo...sometimes aren't willing to work at changing a practice, particularly in a small area."

Integration is easier in places with more people. It helps justifies the cost of team-based health care, which requires a variety of providers and a high volume of patients to pay for their salaries. Buck says this goes back to the idea, which I heard from other industry gurus, that health care is local. For Buck, urban markets elsewhere in the country are likely to have very different needs than where he is in rural south Texas.

"With a concentration of members, you can build more of...the big box, the single big clinic with multiple providers," Buck said. "In rural America, you either up-train the lone doctor and his office staff to be better than they ever were before or you provide them with virtual or telemedicine support."

But the Border Region Behavioral Health Center in Laredo, which sits in Driscoll's coverage area, tells a different story. Project Director Alda Rendon said during an interview at a conference in Austin this fall that her clinic hired a primary care doctor three years ago to serve her patients with mental health issues. Her clients normally don't seek out physical health care, but since the doctor came, she said it "keeps them out of the emergency room."

Rendon's clinic follows the philosophy that Charles Gross of Anthem uses, which is that integration is less a rural-urban issue and more one specific to each practice. By that logic, there are some rural clinics with thriving integrated practices, and some urban ones where it hasn't taken root. "It's more a level of the *practice* sophistication around integrated care," Gross said.

Anthem has taken the idea of hyper-locality and used it to test niche projects. In Las Vegas, it teamed up with the nonprofit Marketplace Solutions and Incentives Project to treat a population of clients prone to violence-related trauma. The program, which Anthem presented at the CFHA conference, used integrated health care to try to prevent

the need for costly repeat emergency room visits. The program is ongoing, but so far, costs have gone down for people who've participated in the program for at least six months. In Texas, Gross says Anthem has a similar program that uses integrated health care to prevent clients with chronic mental, physical and social problems, like homelessness and drug addiction, from resorting to emergency care.

Industry watchers like Greg Scott of Deloitte say health care integration is the way of the future, even if insurers don't cover it fully everywhere yet. In a transcript from a December 2016 Deloitte podcast, Scott said the move toward integration among insurance companies would be "accelerating" in 2017. Scott, who oversees Deloitte's health plan consulting business, says part of what's making this trend possible is the fact that both commercial insurance companies and the federal government are pushing for a new health care payment model — one that pays based on value rather than piecemeal for each service.

The 2015 Medicare Access and CHIP Reauthorization Act, or MACRA, instituted a "value-based" payment system. Just this year, doctors have started to participate in the program, but it only applies to Medicare patients. MACRA is significant for integrated care, though, because it changes reimbursement rules to pay for collaboration among providers. The hope is that eventually this payment model will be more widespread and will make it more feasible for people to set up integrated practices in the future. While Scott said MACRA is part of how the insurance industry is "shifting mightily" toward

integration, he tempered his enthusiasm telling podcast host Rob LaFrentz, “We still have a ways to go.”

With the Tax Cuts and Jobs Act currently making its way through Congress, MACRA could be at risk down the road. That’s because baked into the bill is the removal of the so-called “individual mandate penalty” in the Affordable Care Act, which helps stabilize the health insurance market and keep programs like Medicare funded. If Medicare sees cuts, new programs like MACRA, and thus the future of value-based payment programs throughout the health care system, could be in jeopardy. The AARP opposes the recently passed Senate version of the bill, saying on its website that the bill would cut $25 billion from Medicare in 2018, which “could have major impacts on patient access to health care.”

People without much exposure to mental health issues could look at someone like Kerstin Taylor or Marty and see them as being on the fringes of society — people dealing with something extreme that the average person will never have to grapple with. With that perspective, a five percent statewide rate of “serious mental illnesses,” or the estimated 1.6 million Texans dealing with a substance use disorder, may not seem like a crisis.

The reality is that when mental health is pushed into the wings, the health care system itself suffers. Poor access to regular mental health services means patients end up seeking care in emergency rooms when their mental health becomes a crisis. Between 2006 and 2013, the U.S. government's Agency for Health Care Research and Quality found a 55

percent increase in people with anxiety, depression or stress visiting the emergency room — one of the most expensive places to get treated.

Sometimes it takes a more tangible crisis like the opioid epidemic to help Americans see the result of inadequate mental health care. Nationwide opioid overdose rates have more than doubled between 2005 and 2015 to 10.4 deaths per 100,000 people, up from 5.1, according to the Kaiser Family Foundation. Texas opioid overdose death rates are lower than other states, but they've still gone up 20 percent to 4.7 deaths per 100,000, up from 3.9 deaths during the same time period.

Serrano of the CFHA says integrated care has a role in the opioid epidemic, and it may be a way to bring it into the mainstream. Right now, he says the system is too overwhelmed to get every addicted person into a treatment center, so much of their treatment will take place in primary care clinics. "We have mental health teams that can help primary care providers work with the patients. We're gonna be asked, more and more, to be on the frontline of the opioid crisis for sure," Serrano said.

Changing a health care system requires hard data, numbers and fact-based discussions. But someone like Marty, the seventeen-year-old who's experienced the effects of integrated care firsthand, puts a human face to all the strategizing and calculation. Marty has seen vast improvements in quality of life through integrated services; for Marty, having good mental health means everything.

“It's very liberating when...I can come to terms with my mind,” Marty said. “I wouldn't change anything because it's made me who I am today.”

But mental health does not have to be a crisis to matter. Serrano of the CFHA says he actually prefers the term “behavioral” health, as opposed to “mental,” because it better captures the work he and his colleagues do. “Physicians don’t just need our help with patients crying, but need help with patients not able to stick to a diabetes nutrition plan. We bring an expertise to behavior change,” Serrano said.

Whether calling it behavioral instead of mental changes the way people view mental health in general is not yet clear. Texas, like much of America, has come a long way in reducing stigma, but there’s much work to be done. Mental health professionals like Serrano are skilled at helping change the behavior of an individual, but it remains to be seen if making them part of mainstream health care will have a lasting effect on the culture at large.

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