

Slipping Through the Cracks:

Closing the Gaps in the District's Mental Health System

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District of Columbia
Primary Care Association

DC Primary Care Association

The DC Primary Care Association (DCPCA) is a health action and advocacy organization improving health care and health coverage for the District's low-income, uninsured, and medically vulnerable residents. DCPCA works with its members to advance policy and develop programs like Medical Homes DC that help ensure that everyone gets the right care, at the right time, and in the right place.

Mission

DCPCA's mission is to facilitate the development and sustainability of an effective integrated health care system in the District of Columbia that guarantees access to primary health care and eliminates disparities in health outcomes.

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Executive Summary

Despite spending more per capita on publicly-funded mental health services than the 50 states, the District has failed to provide adequate access to low-income residents in need.¹ This is because the District lacks a comprehensive mental health care system that meets the demand of all at-risk residents, including children 0-8 years old, in need of mental health services. This is due to a number of factors: 1) the absence of sound data detailing the mental health care needs in the District; 2) a narrowly-defined mental health care delivery and financing system, which limits access for residents who are uninsured or on the DC HealthCare Alliance, and does not provide adequate financial support to community providers that offer office-based services; 3) a care coordination system that contains barriers to obtaining services; and 4) a shortage of behavioral health professionals.

While the DC Department of Mental Health (DMH) reportedly serves an estimated 14,000 District residents, there is very little data to demonstrate how many individuals are actually accessing services and being adequately treated. What we do know is that DMH is serving primarily those adults who have Serious and Persistent Mental Illness (SPMI) and children with Serious Emotional Disorder (SED) who are covered by Medicaid. While these are appropriate populations for a state mental health authority to serve, there are thousands of other low-income, at-risk District residents in need of mental health services that the city must not ignore.

A large number of these individuals, who are generally uninsured or have health care coverage through the DC HealthCare Alliance, which does not include a mental health benefit, present at community health centers (CHCs). Unfortunately these safety net providers lack the resources to treat the entire demand. Lack of reimbursement for mental health care and poor care coordination between primary care providers and DMH and its providers have created large gaps in the continuity of care for these patients. The burden of uncompensated mental health care falls on the ever-weakened shoulders of the community health centers. Patients who slip through the cracks of the system decompensate into crisis and present in the District's emergency departments.

It is imperative that the District develop a mental health system that serves not only persons with serious mental illness, but also allows low-income individuals, with moderate mental health issues, to have access to care. In order to achieve this, the District must reorganize the way mental health care for low-income residents is financed and delivered, commit to increasing the resources available to non-DMH certified providers, and remove the barriers that prevent individuals from accessing appropriate services. First and foremost, however, a needs assessment must be conducted in order for the District to know how and where to direct resources. As with medical care, providing access to basic mental health prevention and treatment services will reduce emergency room and hospital costs, as well as provide individuals the opportunity to be treated holistically in their medical home and receive the right care, at the right time, and in the right place.

The following recommendations highlight ways in which the District can create a more comprehensive mental health care delivery system that is more cost-effective and leads to better health outcomes:

¹ The National Alliance on Mental Illness. *Grading the States; A Report on America's Health Care System for Serious Mental Illness*. March 1, 2006.

Policy Recommendations

1. Conduct a Mental Health Needs Assessment

Before the Department of Mental Health can effectively implement priority populations, which would determine which District residents should be served by the public system, or develop a comprehensive mental health care delivery and finance system, it must first find out how many District residents - both adults and children from 0-18 - require mental health services. Once the District has a picture of the potential population in need of services, it can develop a system to meet the need.

2. Establish a Mental Health Benefit with Expanded Formulary Under the DC HealthCare Alliance

An Alliance mental health benefit package should mirror that covered by the managed care organizations (MCOs) under Medicaid, and target mental illness in the general population, not comprehensive and intensive services for individuals with severe mental illness that are already provided by DMH under Mental Health Rehabilitation Services (MHRS).

In addition, the current Alliance formulary should be expanded to cover newer psychotropic medications, which will give more treatment options to practitioners, and provide a better system of care for patients. (There are also barriers to integrating primary and mental health care under DC Medicaid. The Medical Assistance Administration (MAA) should amend the requirements for free-standing mental health clinics, and allow primary care providers to write prescriptions for some psychotropic medications).

3. Create a More Effective Care Coordination System

There must be better coordination of care for those individuals being served by DMH and non-Core Service Agency (CSA) community providers, as well as the managed care organizations that are responsible for their care. Bridging this gap is key to providing continuity of care and ensuring a strong safety net for mental health consumers being served in the District.

In addition, DMH needs to improve care coordination services provided by the Access Helpline. There is currently insufficient clinical staff to provide linguistically appropriate services, and individuals are often not assisted with or adequately linked to services.

The District should also investigate ways to assist community providers in removing internal barriers to care coordination. A number of state Medicaid programs have begun to provide reimbursement for disease or case management programs, and some private health plans have begun compensating for this. MAA should consider applying for a waiver or state plan amendment, or even look for opportunities within the District's current State Plan or managed care contracts, that would provide direct reimbursement to providers for these services.

4. Amend the District of Columbia Health Professional Recruitment Program Act of 2005 to Include More Behavioral Health Professionals

The "District of Columbia Health Professional Recruitment Program Act of 2005" created a health professional loan repayment program to recruit and retain qualified health professionals to work in underserved areas of the District. Unfortunately, the only behavioral health professionals eligible for the program are psychiatrists. This act should be amended to include more behavioral health professionals, such as licensed clinical social workers, psychologists, and licensed professional counselors, to assist health centers in recruiting and retaining these much needed professionals.

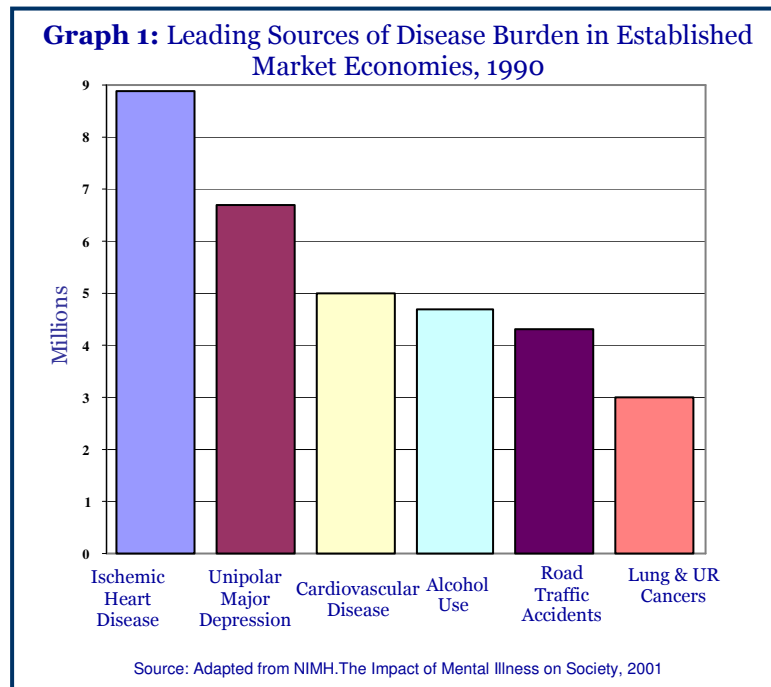
Introduction

Despite spending more per capita on publicly-funded mental health services than the 50 states,¹ the District has failed to provide adequate access to low-income residents in need. The reason being that the District lacks a comprehensive mental health care system that meets the demand of all at-risk residents, including children 0-8 years old, in need of mental health services. This is due to a number of factors: 1) the absence of sound data detailing the mental health care needs in the District; 2) a narrowly-defined mental health care delivery and financing system, which limits access for residents who are uninsured or on the DC HealthCare Alliance, and does not provide adequate financial support to community providers who offer office-based services; 3) a care coordination system that contains barriers to obtaining services; and 4) a shortage of behavioral health professionals.

When preventively targeting populations who are most at risk for mental illness, the focus of public mental health systems is generally directed at the homeless, poor, and uninsured. The District, however, falls short in meeting this target. Eligible DC residents who are covered by Medicaid have access to the mental health services provided within the program. However, residents who are ineligible for Medicaid, such as DC HealthCare Alliance (Alliance) patients and the uninsured, have limited access to mental health services and psychotropic medications. This population is dangerously and disproportionately at risk for mental illness, and thus the District must develop a comprehensive mental health care system that meets the demand of all at-risk residents in need of mental health services.

Background

Mental illness is the second leading cause of disease burden in the United States, and ranked first among illnesses that cause disability (Graph 1).^{2,3}



¹ The National Alliance on Mental Illness. *Grading the States; A Report on America's Health Care System for Serious Mental Illness*. March 1, 2006.

² Murray CJL, Lopez AD, eds. *The Global Burden of Disease and Injury Series, Volume 1: A Comprehensive Assessment of Mortality and Disability From Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press. 1996.

³ New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*. July, 2003.

Approximately 20 percent of the U.S. population is believed to have some form of mental health disorder, and 5 percent is believed to have serious mental illness, with a diagnosis of schizophrenia, major depression, or bipolar disease.^{4,5} Though there is limited data on children, about 20 percent of children are estimated to have mental disorders with at least mild functional impairment; children and adolescents with Serious Emotional Disorder (SED) number approximately five to nine percent of children ages nine to seventeen.⁶

This high prevalence of mental illness within the general population has made a significant impact on inpatient hospital care and emergency department use. Left untreated, symptoms of mental illness can become exacerbated and lead to repeated attendance and use of emergency resources. For instance, people with depression visit the emergency room seven times more frequently than the non-depressed population.⁷ Nationally, since 1992, emergency department visits for psychoses excluding depression has gone up by 51 percent.⁸ Hospital stays related to mental health and substance abuse disorders account for roughly one-fourth of total resources used; 24 percent of all adult hospital stays, 29 percent of days in the hospital, and 22 percent of total hospital costs.⁹ Therefore, psychiatric-related emergency department visits may pose a substantial and growing strain on the District's emergency facilities.

Additionally, mental illness has a direct and substantial effect on lifestyle and productivity. Among the five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) that account for 49 percent of total health care costs and 42 percent of illness-related lost wages, mood disorders rank third in healthcare costs, first in work loss costs and second in total costs.¹⁰ The United States spends approximately \$100 billion in direct medical and workplace costs associated with mental illness each year.^{11,12} Undiagnosed mental illness is also having a costly effect on the nation's criminal justice system. According to the Bureau of Justice Statistics, in 2005, 64 percent of jail inmates had a mental health problem.¹³ Perhaps the most alarming statistic has revealed that patients with severe mental illness die 25 years earlier than the average population. Additionally, patients who suffer from mental illness are at a higher risk for multiple, co-morbid diseases that are compounded by depression.¹⁴

Mental illness is considerably more prevalent in low-income populations due to exposure to violent events, crime, and poverty.¹⁵ According to a survey conducted by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services, higher prevalence rates for major depression, generalized anxiety, and panic attacks were observed among adults with family incomes less than \$20,000.¹⁶ The uninsured population is more than twice as likely as the general population to have a mood or anxiety disorder.¹⁷

⁴ Mental Health: A Report of the Surgeon General, 2002.

⁵ NAMI. Policymaker's Fact Sheet. September, 2002.

⁶ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

⁷ Johnson J, Wiessman MM, Klerman GL. *Service Utilization and Social Morbidity Associated with Depressive Symptoms in the Community*. Journal of the American Medical Association. 1992(267) 147-83.

⁸ CDC. Vital and Health Statistics, Series 13, Number 150. *Trends in Hospital Emergency Department Utilization: United States 1992-99*. November, 2001.

⁹ Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project. *Fact Book 10: Care of Adults with Mental Health Substance Abuse Disorders in US Community Hospitals*. 2004.

¹⁰ Bartels S. *Integrating Mental Health in Primary Care: An Overview of the Research Literature*; Presentation to NAMHPD Technical Report. Behavioral Health/Primary Care Integration – Guidance for Public Sector Implementation Work Group. June, 2004.

¹¹ Greenberg PE, et al. *Calculating the Workplace Cost of Chronic Disease*. Business and Health. 1995. 3; 27-8.

¹² Rice DP, Miller LS. *Health Economics, and Cost Implications of Anxiety, and Other Mental Disorders in the United States*. British Journal of Psychiatry. 1998. 34; 4-9.

¹³ James D, Glaze L. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. *Mental Health Problems of Prison and Jail Inmates* September 2006, NCJ 213600.

¹⁴ Parks J, Svendsen D, Singer P, Foti, ME, Mauer B. *Morbidity and Mortality in People with Serious Mental Illness*. National Association of State Mental Health Program Directors. October, 2006.

¹⁵ Lynch JW, Kaplan GA, Salonen JT. *Why Poor People Behave Poorly? Variation in Adult Health Behaviors and Psychosocial Characteristics by Stages of Socioeconomic Life Course*. Soc Sci Med. 1997. 44:809-19.

¹⁶ Wayne C. Dickey, Ph.D., Stephen J. Blumberg, Ph.D. Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention *Prevalence of Mental Disorders and Contacts with Mental Health Professionals Among Adults in the United States*. National Health Interview Survey, 1999.

¹⁷ Mauksch LB, Tucker SM, Katon WJ, Russo J, Cameron J, Walker E, Spitzer R. 2001. *Mental illness, Functional Impairment, and Patient Preferences for Collaborative Care in an Uninsured, Primary Care Population*. Journal of Family Practice. (50)1.

An Absence of Sound Data Detailing the Mental Health Care Needs in the District

The DC Department of Mental Health (DMH) has collected very little data on whom they are serving and what services are being provided. A DMH Organizational Assessment conducted by KPMG LLP in 2006, noted that “DMH has never performed a needs assessment to define the potential population of people needing mental health services, the types of services they require, and the mix of Medicaid vs. non-Medicaid eligible consumers to help the program arrive at reliable cost of services estimates.”¹⁸ As a result, none of the program or budget planning done by DMH has been led by sound data. Recently, DMH indicated that there are *probably* about 14,000 individuals in the DMH system, but that the department does not have a definitive number at this time. For far too long, DMH has been granted a very large budget while showing very few outcomes. The large budget is most likely warranted based on the anecdotal need for services, but a more efficient and accountable use of resources is sorely overdue.

As recommended by KPMG, DMH must first and foremost conduct a needs assessment to determine who in the District requires mental health services, especially as this relates to insurance status, what services are most needed, and the most appropriate setting in which to provide these services. Once this has been accomplished, the District will have a guide as to how to develop a comprehensive mental health care system that is both cost-effective and outcome-driven.

A Narrowly Defined Mental Health Care Delivery and Finance System

The District's current mental health care delivery and finance system precludes the city from providing the most cost-effective and appropriate treatment to its residents. In 2001, in response to the Dixon Court Ordered Plan,¹⁹ the Department of Mental Health developed the Mental Health Rehabilitation Services (MHRS) system to provide community-based mental health care to District residents. MHRS is geared towards adults with SPMI and children with SED.²⁰ In order for mental health providers to receive reimbursement under the MHRS system, DMH requires providers to become certified as a Core Service Agency (CSA). The process to become a CSA is very onerous, requiring agencies to greatly expand their administrative and financial management capability and meet new staffing requirements. In addition, in 2006, DMH placed a moratorium on certifying more core service agencies because there are already over 50 in operation.

¹⁸ KPMG LLP. Department of Mental Health Organizational Assessment. Commissioned by the DC Office of the Deputy Mayor for Children, Youth, Families and Elders. August, 2006.

¹⁹ In February 1974, a class of individuals civilly committed to St. Elizabeths Hospital, including lead plaintiff William Dixon, filed suit against the federal government (which operated St. Elizabeths) and the District of Columbia (which was responsible for community mental health centers in the District). The plaintiff class, which ultimately included individuals at future risk of hospitalization due to the lack of community services, sought community-based mental health treatment for class members whose mental illnesses were not deemed by their treating professionals to be sufficiently severe to require hospitalization. In December 1975, the District Court ruled that individuals subject to the Ervin Act have a statutory right to treatment in the least restrictive setting, including placement in alternative community facilities when treating professionals have determined such treatment is appropriate. In 1980, following two years of negotiations, the Federal and District defendants and counsel for the plaintiff class, agreed to the entry of a consent order and an implementation plan. The order established the Dixon Implementation Monitoring Committee as a mechanism for overseeing the execution of the Plan, including tracking the availability of necessary resources, advising the Court on systemic obstacles to reform, and reporting the concerns raised by the class members.

²⁰ Severe mental illnesses are brain disorders, including Schizophrenia, Bipolar Affective Disorder, recurrent Major Depression, etc that can be treated and managed effectively if an individual has access to a combination of medication, supportive counseling and community support services. Some common childhood SEDs include anxiety and mood disorders (depression), attention deficit and disruptive disorders, elimination disorders or eating disorders.

As a result of this new emphasized structure and onerous certification process, the robust network of free-standing mental health clinics has virtually disappeared. Many of these clinics converted to CSAs, but a number of the free-standing clinics, which specialized in psychotherapy and office-based services, were not equipped to become CSAs and provide more intensive MHRS services.

Priority Populations

In 2006, the DC Department of Mental Health released proposed rules to define those consumers designated as “priority populations.” The DC Primary Care Association’s (DCPCA) Mental Health Task Force was concerned that the end result of the regulations as proposed would be that only persons with the most severe mental illness would be considered a priority. Persons currently stabilized and in the community with intensive services would be required to decompensate to a crisis level in order to be classified as members of the priority population. Another of the Task Force’s concerns stemmed from the fact that DMH has very little data on whom they are serving so they admittedly have no way of knowing how many people in the system would actually be affected by the proposed rules. Due to the fragility of the current mental health safety net for individuals who are non-SPMI and without insurance, the Task Force felt that the way DMH was defining priority populations would leave a large number of people in need without access to services.

As a result, the Task Force submitted recommendations to DMH, which focused on a commitment to a recovery-based system of care by including broad-based criteria from which priority populations can be drawn. The recommendations were intended to ensure that both an adult with SPMI and one diagnosed with a less severe mental health issue would be able to access services through DMH, albeit the level of guaranteed services would vary based on severity of illness or social circumstance.

Since they are no longer eligible to receive reimbursement out of DMH’s pot of local funds to provide these services to their uninsured patients, there are very few remaining office-based free-standing mental health clinics. Community health centers (CHCs) struggle to fill this gap. The conversion or closure of many free-standing mental health facilities has left many uninsured residents in the community in need of mental health services without adequate support, leading to an increased reliance on the emergency room for care.

In addition to structural changes, the financing mechanism that was developed when MHRS was implemented has also created a major barrier not only for providers, but consumers as well. The Dixon plan calls on DMH to prioritize the types of individuals being served and rely heavily on Medicaid as a major funding source. DMH implemented the Medicaid Rehabilitation Option (MRO) in 2001, which allows it to receive a 70 percent match on covered services to Medicaid patients. Nonetheless, the Court requires that “persons not be discriminated against based on their eligibility or non-eligibility for Medicaid, Medicare, or private insurance coverage in assessing or meeting service needs. Rather, the provision of services shall be based upon an individual clinical assessment of the client’s needs consistent with the Department’s promulgated rules for “priority populations.” However, the

rendering of services has been largely based on budgetary factors rather than medical necessity. This is because DMH utilizes a system of task orders. A task order represents the maximum amount of services that DMH will purchase during a given fiscal year. Services provided in excess of the amount allocated under a task order, which are not calculated based on a needs assessment, are not reimbursed. Consequently, CSAs are often limited in the number of consumers that they can serve. Many of these patients end up at the DC Core Service Agency (DCCSA) run by the DMH. The DCCSA offices are reported to be overwhelmed by the client volume - some reports suggest that

some case managers have approximately 100 clients and psychiatrists have over 400 on their caseload. In addition, the DCCSA has been inefficient at retrieving all possible Medicaid revenue, resulting in wasted local dollars that could have been spent on serving more individuals. For example, in fiscal year 2006, the DCCSA experienced a \$14 million gap between gross revenue and actual costs.²¹ Still, other individuals may end up at the emergency room (er) when their condition worsens to a crisis state. This is a far costlier outcome for the District, and an unnecessary and added health burden to the patient.

In addition to the task order system creating a barrier to services, a focus on Medicaid reimbursement has led to the skewing of resources to individuals with Medicaid coverage. This is evident in the small allocation of local dollars for MHRS in the DMH Fiscal Year 2007 Budget to serve non-Medicaid clients – just \$4 million. This was coupled with the fact that, over the last few years, the department's faulty claims processing system led to millions in unpaid provider claims - \$16.3 million in 2005²² - creating cash flow problems for the majority of CSAs. As a result, a number of community providers had to close their mental health intake episodically, mostly to non-Medicaid clients for whom they did not have sufficient local dollar task orders, and re-open only as task order limits were increased or new task orders were issued.

Fortunately, the DC Council allocated an additional \$10 million after the start of the 2007 fiscal year once it was realized that funds were insufficient to serve these non-Medicaid consumers. For fiscal year 2008 this amount was increased to \$17.9 million in recognition of the high need of non-Medicaid funds for the MHRS program. Unfortunately, the amount is not based on any sound utilization data. The DMH does not track how many Alliance, or uninsured consumers it is serving so it is difficult to predict whether the \$17.9 million will meet the entire need. Moreover, this funding is restricted to CSA providers. CHCs are restricted from accessing these funds for non-Medicaid mental health patients, even though they are treating a large number.

Lack of Funding for Community Providers to Support Office-Based Services

MHRS was not designed to serve the estimated 60 to 70 percent of the population needing mental health services that can be appropriately managed in traditional, office-based mental health services, such as assessment, medication management, and therapy. This is because DMH has transformed from “largely an office and clinic-based system” to one in which a “minimum of 50 percent” of services are delivered in non-office or non-clinic settings.²³ Many of the consumers who do not require the MHRS level of treatment are seen in the community health centers. (Appendix I contains the six most common mental illnesses diagnosed in community health centers). For many individuals, a community health center is their complete medical home, where they not only go for medical care, but where they will also seek and be treated for mental health issues. In fact, up to ten percent of primary care medical appointments are for problems stemming from psychosocial issues.²⁴ Unless the health centers are certified as a CSA, which only two are, they receive no money from DMH for non-Medicaid mental health patients, except in the case of contracts for specific services such as day treatment and crisis beds. Lack of reimbursement has forced some health centers to refer out all mental health care, and others to vigorously fundraise to sustain their programs.

²¹ Court Monitor Dennis R. Jones. Report to the Court. July 13, 2007.

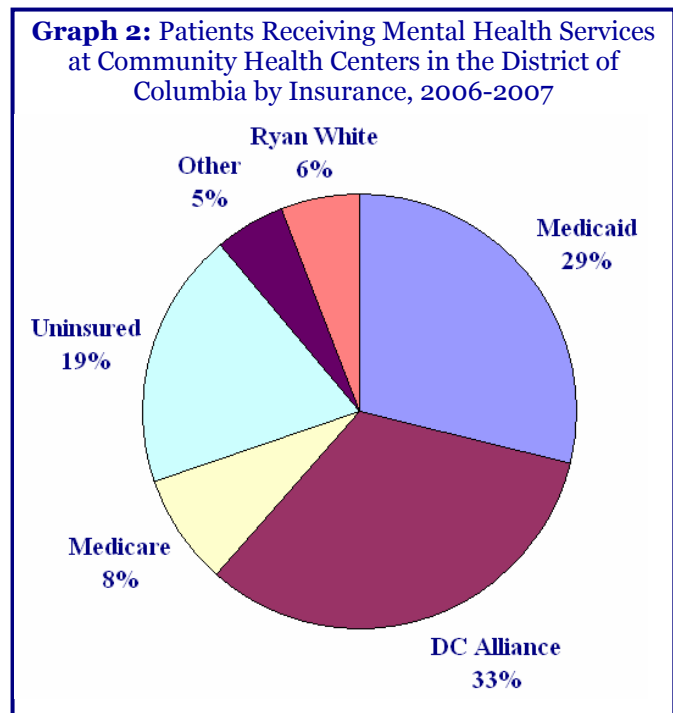
²² National Alliance on Mental Illness. *Grading the States: A Report on America's Health Care System for Serious Mental Illness*. March 1, 2006.

²³ Ibid.

²⁴ Robinson P, Reiter J. *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. Springer US. 2007

Low-income and non-White women are particularly unlikely to seek care in mental health settings, and more likely to seek help from primary health care providers.²⁵ This led many community health centers to integrate mental health services into their practices, thus providing a comprehensive range of care to their patients for both mental and somatic health needs. Within the CHCs, 52 percent of patients seen for behavioral health issues are uninsured or have the Alliance (graph 2). These patients lack mental health coverage and have access to a limited formulary of psychotropic drugs, of which Zoloft is the only SSRI available. As a result, a large portion of the mental health services provided by CHCs are not reimbursable, forcing these providers to rely heavily on private donations. Inconsistent and variable funding is an obstacle to hiring trained staff and sustaining quality care for mental health treatment. A reliance on CHCs without adequate reimbursement creates an unstable mental health care system for low-income, un- or under-insured DC residents.

Recently, DCPCA conducted a survey of mental health services and uncompensated care provided by the District’s community health centers. Ten centers responded, of which only eight offer mental health services.²⁶ Additionally, interviews were conducted with the primary care staff at nine community health centers in the District. The results of the survey and subsequent interviews reveal the breadth of the problem and the necessity for action. The eight reporting community health centers spent a combined total of over \$6 million on mental health services a year. In these centers, over 9 percent of the patients receive behavioral health services, yet only 6.3 percent of the centers’ total budgets are dedicated to mental health programs. There are over 1,600 Alliance patients receiving uncompensated mental health treatment - nearly 33 percent of all patients treated for mental health at these centers (graph 2). Combined with the uninsured patients, these community health centers are providing over \$1.3 million in uncompensated mental health care – millions of dollars that these centers must raise on their own to provide treatment for these patients.



What is more discouraging is that the prevalence of mental illness is far greater than the capacity of these centers to offer services. All of the centers interviewed explained the frustration of turning away patients, limiting treatments, and minimizing screening for mental illness because of the lack of resources to support patients in need of these services. (A complete list of barriers identified by the community health centers is compiled in Appendix II). Funding to community health centers and free-standing mental health clinics to provide adequate, non-MHRS services to low-income individuals would provide resources to sustain and expand services among the centers’ mental health programs. This would allow patients to get the right care, at the right time, and in the right place.

²⁵ O’Malley AS, Forrest CB, Miranda J. *Primary Care Attributes and Care for Depression Among Low-Income African American Women*. *American Journal of Public Health*, Vol 93, No. 8. August, 2003.

²⁶ Community Health Centers that participated in the behavioral health survey and interview include Bread for the City, Community of Hope, Columbia Road Health Services, Family Health and Birth Center, Family and Medical Counseling Inc., La Clínica del Pueblo, Mary’s Center for Maternal and Child Care, So Others Might Eat, Unity Health Care, and Whitman-Walker Clinic.

Limited Access for Residents who are Uninsured or Have Health Coverage through the DC HealthCare Alliance

Thanks to diligence from the advocacy community and the commitment of DC's elected officials, the District has arguably the most progressive health care coverage in the nation. No state in the nation has committed to publicly fund coverage for all residents with incomes below 200 percent of the Federal Poverty Level (FPL). Due to this commitment, the District has an uninsurance rate of less than 10 percent. That being said, there still remain a number of coverage gaps, especially in terms of mental health.

DC HealthCare Alliance covers over 45,000 District residents



Community health centers provide mental health services to many Alliance and uninsured patients without reimbursement, shouldering the cost of this uncompensated care and further fraying an already vastly weakened health care safety net.

The DC HealthCare Alliance (Alliance) provides health insurance to individuals with incomes at or below 200 percent FPL who are ineligible for Medicaid. Individuals on the Alliance are highly vulnerable to mental health problems, but lack coverage for mental health services. As with primary medical care, providing access to basic mental health prevention and treatment services will reduce emergency room and hospital costs. The program serves a number of homeless individuals who are especially vulnerable to mental illness, as well as a large number of immigrants and undocumented individuals, who in particular receive medical and

mental health services at community health centers. Of the approximately 45,000 enrollees as of July 2007, just over half were U.S. citizens. In a study on the state of Latino health in the District conducted by the Council of Latino Agencies, 59 percent of respondent reported having the Alliance and 68.8 percent said they would seek health care or health-related advice at a clinic or health center over any other medical site.²⁷ An earlier study by the same group found that 25 percent of DC Latinos and 34 percent of DC Latinas answered affirmatively when asked if they suffer from depression. This population, without access to mental health coverage and care, is not being adequately served by the District.

The District's community health centers provide mental health services to many Alliance and uninsured patients without reimbursement, shouldering the cost of this uncompensated care and further fraying an already vastly weakened health care safety net. Unfortunately many of the health centers cannot even hire psychiatrists, let alone other mental health staff, due to the cost and lack of reimbursement. It is to the District's advantage to consider and institute options that provide mental health access and coverage to Alliance patients. This would strengthen the District's safety net and build a continuum of care that addresses the health of the entire patient without differentiating between the body and the mind.

The top barrier to mental health treatment for those who are uninsured or on the Alliance that was noted by CHCs is the lack of access to psychotropic medication. The Alliance only covers two or three older psychotropic drugs, and the only SSRI medication on the formulary is Zoloft. Once this option is explored, there is no other medication therapy available to the patient or physician. If the patient doesn't respond or responds adversely, the only other option is referring out. If a patient requires medication outside of the formulary, they can access the Department of Mental Health's (DMH) pharmacy only if they are first referred to a Core Service Agency and officially entered into

²⁷ McClure H, Jerger K. *The State of Latino Health in the District of Columbia*. Council of Latino Agencies. Washington, DC. September, 2005.

the DMH system. In addition, DMH requires that the prescription be signed by a psychiatrist, thus preventing primary care physicians from being able to prescribe psychotropic medications. (This is also a Medicaid requirement for free-standing mental health clinics). Only two of the District's community health centers are CSAs, and few can afford to have psychiatrists on staff. The current system creates significant barriers for individuals and is severely disruptive to an individual's treatment, making adherence extremely difficult. In addition, this creates unnecessary costs for DMH to have these individuals in the system when they are not even accessing MHRS services. Altering this process to ease restrictions on prescribing psychotropic drugs would increase access to this needed and effective treatment.

With such a large number of patients being served for mental health issues at the health centers, it is not viable or even best practice to refer out all pharmaceutical intervention for behavioral health care. Therefore, if nothing else, an expansion of the Alliance's formulary to include more psychotropic drugs will increase the quality of care for this patient population and provide prescribing physicians more options for better treatment. Primary care providers could more completely care for the needs of mental health patients at their medical home if they were given more treatment options.

A Care Coordination System that Contains Barriers to Accessing Care

Many of the District's community health centers have expressed a sincere concern for patients that must be referred to the Department of Mental Health for MHRS. Many of the clinicians at the health centers feel as if they are sending their most vulnerable patients into the unknown with only a telephone number and the address of the DMH provider, without any guarantee that their patient will be able to navigate the tumultuous DMH system, or be sent to the correct or appropriate provider. The centers try to follow up on these patients, but they have limited resources and no other referral options for many patients. This sentiment is echoed by the managed care organizations, which often have to refer patients to DMH for MHRS services. They indicate that it is very difficult to receive follow-up information on the services provided to their members – obviously a barrier to managing a person's care. Furthermore, staff in hospitals and community health centers throughout DC have voiced their concern for the lack of continuation of care upon discharge of psychiatric patients after crisis stabilization. A major problem also exists in terms of trying to identify services for the 0-8 years old population. Because many of the centers do not have access to psychologists and psychiatrists, DMH is usually the only choice in giving care to behavioral health patients.

Many primary care physicians are forced to send patients with mental health referrals to DMH with only a telephone number and an address



The Access Helpline lacks a Spanish-speaking option for patients referred out to DMH



Often the Helpline chooses to provide a call-back to patients, even though many do not own a telephone

Additionally, there are multiple barriers to using the DMH Access Helpline, which provides information on services and links individuals to providers. Health centers explained that many times the Helpline sends patients to treatment centers that do not take their insurance, or are directed to the wrong services. Often the Helpline will offer to call the patient back, but many of these patients do not have access to a continuous home phone number. Of utmost concern is the limited Spanish-speaking clinical staff at the Helpline who can assist patients. While consumers can go directly to a CSA for services, the Helpline remains the main point of intake used by those consumers and

providers unconnected to DMH. Thus, it must be readily accessible, easy to use for all residents, linguistically appropriate, and efficient enough to supply correct information. The lack of a reliable referral and intake system results in the neglect of the most vulnerable patients, fueling a cycle of decompensation and crisis.

Community health centers also face internal barriers to achieving appropriate care coordination. The primary care setting is a catchment for those with a mental illness. Patients are screened, identified, treated and referred by the primary care staff. The standard model of care for integrated behavioral health treatment is the use of a case manager. This staff position works to refer, screen, conduct disease and medication management, and follow up on treatment. This position coordinates care between the mental health and primary care providers, improving access to mental health services and ensuring care management for behavioral health. Unfortunately, this position is not readily reimbursable by DC Medicaid or the Alliance. As a result, health centers have not been able to employ case management strategies to their full potential.

A Shortage of Behavioral Health Professionals to Serve in the Community

There are a number of areas in the District, especially in wards 7 and 8, that have been certified as Mental Health Professional Shortage Areas by the Health Resources and Services Administration (HRSA). Many community health centers have indicated that it is difficult to recruit and retain qualified mental health staff, especially licensed clinical social workers. It is difficult for community health centers to compete with the private sector, which can offer these health professionals much more lucrative salaries.

Unfortunately, under the DC Health Professional Loan Repayment Program, which was implemented in 2006, psychiatrists are the only behavioral health specialists eligible for loan repayment opportunities. The District needs to provide incentives to more categories of behavioral health professionals in order to close the immense shortage that exists and as a result increase access to mental health services in the city's most underserved areas.

Primary care providers, including community health centers, are often the first and only health care providers that treat many of the patients with mental illness. Nationally, among primary care patients, 25 percent have a mental disorder. Unfortunately, up to 50 percent of these patients go undiagnosed in the general medical setting.²⁸ The current health care system in the District of Columbia does not allow primary care providers the distinct opportunity to improve the quality of care for those who suffer from mental illness by addressing their needs on the front-end during their regular doctor visit.

From a patient's perspective, mental health is not separate from overall health. Paying attention to behavioral health symptoms is an integral part of caring for a patient's total health. The health care system too often distinguishes physical health from mental health by limiting coverage for mental health services. This hampers the wellbeing and health of a population that is predisposed to behavioral health issues. Essentially, services are withheld from the neediest populations.

In response to these needs, DCPCA offers the following recommendations to the District to close the gaps in the mental health care system, and create a comprehensive system of care that meets the demand of all at-risk residents in need of mental health services.

1. Conduct a Mental Health Needs Assessment

Before the Department of Mental Health can effectively implement priority populations or develop a comprehensive mental health care delivery and finance system, it must first find out how many District residents - both adults and children from 0-18 - require mental health services. Beyond just the numbers, it is imperative to gather data on diagnosis, as well as basic demographic information, such as age, gender, ethnicity, income, insurance status, and housing status.

Once the District has a picture of the potential population in need of services, it can develop a system to meet the need. The department will no longer have to rely on guesses to guide its efforts, but will be able to build a new mental health delivery and finance system that will cost-effectively treat individuals in the most appropriate settings, and lead to improved health outcomes.

2. Establish a Mental Health Benefit with Expanded Formulary Under the DC HealthCare Alliance

An Alliance mental health benefit package should mirror that covered by the Managed Care Organizations (MCOs) under Medicaid, including psychiatric assessment, medication management, individual and group therapy, a comprehensive formulary of psychotropic medications, and hospitalization if necessary. This benefit should target mental illness in the general population, not comprehensive and intensive services for individuals with severe mental illness or serious emotional disorders that are already provided under Mental Health Rehabilitation Services (MHRS). If an Alliance patient is identified as needing more intensive mental health services, such as MHRS, they should be transitioned to DMH and be assessed for Medicaid eligibility. If a patient is undocumented or otherwise ineligible for Medicaid and needs MHRS services, they will have to be paid for through the DMH with local funds. In the instance that an Alliance patient is referred for MHRS, it is imperative that Core Service

²⁸ Dea RA. The Integration of Primary Care and Behavioral Healthcare in Northern California. Kaiser-Permanente. Psychiatry Quarterly 71(1):17-29. Spring 2000.

Agencies and the MCOs work closely to ensure that there is a seamless transition for both continuity of care and billing purposes. Medicaid MCOs already facilitate this transition for their patients to MHRS. Therefore, implementing this continuation of care with Alliance patients should not be difficult, especially since the Medicaid and Alliance MCO contracts will be combined going forward. (See Appendix for details on the cost of adding an Alliance mental health benefit.) It has been noted by the MCOs, however, that they have difficulty following up and getting feedback from DMH providers for their Medicaid clients once their patient has been referred to a CSA. Thus, it is crucial that better coordination exist between MCOs and DMH providers in order to meet the needs of these patients and to prevent them from falling through the cracks.

Expanding the Alliance formulary to cover newer psychotropic medications will give more treatment options to practitioners, and provide a better system of care for patients. In addition to the pharmacy issues related to the Alliance, there are barriers under Medicaid that prevent better integration of primary and mental health care. Thus, the Medical Assistance Administration should amend the requirements for free-standing mental health clinics, and allow primary care providers to write prescriptions for psychotropic medications.

3. Create a More Effective Care Coordination System

The Department of Mental Health has long been disconnected from the needs of many in the community who desperately need access to mental health services. When a patient is referred to DMH for services, they are often given only a number for the Access Helpline and an address and then left to navigate the complicated DMH system. These patients, in an already vulnerable state, must navigate a fickle and non-user-friendly environment. Patients who are unable to access DMH services often decompensate and reappear in local emergency rooms when they go into crisis. Bridging the gap between DMH and community health providers is key to providing continuity of care and ensuring a strong safety net for mental health consumers being served in the District. In addition, the dearth of linguistically appropriate clinical staff available through the Access Helpline must be immediately rectified by DMH.

In addition to improving the Access Helpline, the District should investigate ways to assist community providers in removing internal barriers to care coordination. In models throughout the nation, as well as in DC community health centers, case managers serve as an integral link between mental health and primary care. Case managers are used in a variety of capacities to screen, refer, treat, and follow up with patients who identify as needing behavioral health treatment. Case managers are identified as a standard of care for evidence-based treatment of behavioral health patients.

A number of state Medicaid programs have begun to provide reimbursement for disease or case management programs, and some private health plans, such as Aetna, have begun compensating for this. The Medical Assistance Administration should consider applying for a waiver or state plan amendment, or look for opportunities within the District's current State Plan or managed care contracts, that would provide direct reimbursement to providers. Options such as coverage for case management, care coordination, or disease management would help support behavioral health treatment in community health centers. Investing in case managers will work to close the gap in mental health care, link resources, and provide the much needed bridge between primary care identification and appropriate mental health treatment.

4. Amend the District of Columbia Health Professional Recruitment Program Act of 2005 to Include More Behavioral Health Professionals

In 2006, then Mayor Anthony A. Williams signed into law the “District of Columbia Health Professional Recruitment Program Act of 2005.” This law created a health professional loan repayment program to recruit and retain qualified health professionals to work in underserved areas of the District. Unfortunately, the only behavioral health professionals eligible for the program are psychiatrists. While this is helpful, many health centers have a difficult time recruiting other types of behavioral health staff, such as licensed clinical social workers, which are needed to serve their vulnerable patients. These professionals are able to earn much more lucrative salaries in the private sector so providing an incentive for them to work at community health centers is greatly needed. The DC Health Professional Recruitment Program Act should be amended to include more behavioral health professionals, such as licensed clinical social workers, psychologists, and licensed professional counselors, to assist health centers with recruiting and retaining these much needed professionals.



Conclusion

The District of Columbia has always been a leader in providing care and coverage for the poor. The city spends more per capita than any of the 50 states on health care and the DC HealthCare Alliance is like no other program in the nation. The expansion of the dental benefit in the District's Medicaid program was groundbreaking, and progressive eligibility criteria continue to be expanded. Inherent in these innovations is a response to need. The need now before the District is an improved mental health safety net.

Many District residents who are ineligible for Medicaid and are in need of behavioral health care cannot access basic services or resources such as medications or counseling. This lack of access is amplified in the high dependency on the emergency department during patient crisis and the overwhelming demand on the limited resources in community health centers. While stigma still exists, it is now widely recognized that it is no longer convenient or cost-effective to deny treatment for behavioral health. If left untreated, mental illness leads to compounded and chronic physical illnesses with cycles of decompensation, crisis, and in some cases death. These physical and mental manifestations lead to a greater dependency on resources when the patient is left untreated than if they were able to access and receive preventive treatment for a manageable condition.

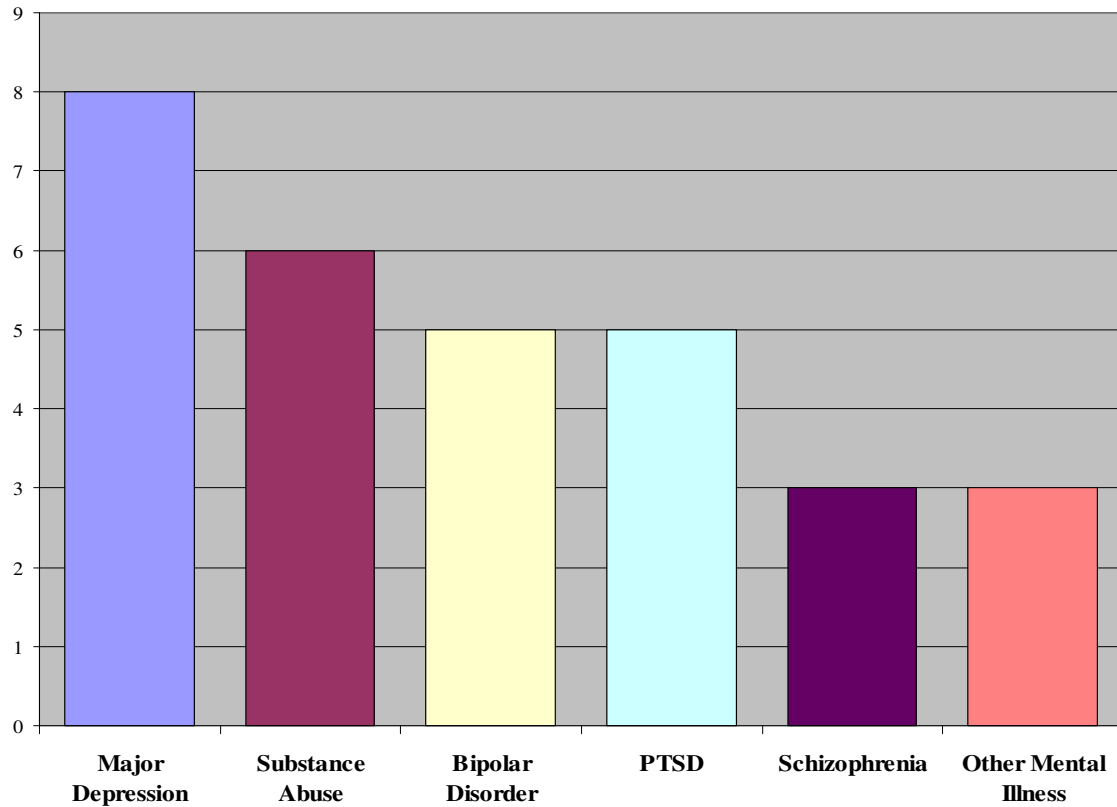
The recommendations offered are not simply reorganizing streams of funding, but inherent changes in a system that differentiates between somatic and mental health treatment. Refusing to cover behavioral health care is a fiscal decision, and one that is against current best practice in medicine. Barriers to acquiring services or obtaining resources is a masked form of diminished access.

The current mental health care safety net in the District is very fragile. Community health centers struggle to maintain the resources needed to continue their mental health programs and many patients are falling through the cracks of a broken referral system. The consequences of inaction will be a continued strain on health center resources and increased presence of mentally ill individuals in other public domains such as emergency rooms, correctional facilities, and homeless shelters.

The problem of the mental health safety net in the District is one that involves key community stakeholders. By adopting these recommendations, the city can target interventions at the community level. Mental health care and coordination can be accessible with a reasonable investment in the health of the community and a renewed commitment to the quality of care for DC residents.

Appendix I.

Most Common Mental Illnesses Diagnosed in Community Health Centers in the District of Columbia



Source: Survey results from 10 Community Health Centers on the most common mental illnesses seen in their centers. August, 2007.

Appendix II.

DC Community Health Centers Identified Barriers to Integrated Primary Care and Mental Health Treatment

Barriers Identified

- The Alliance formulary is too narrow.
- There is a lack of access to psychiatry. Health centers don't know whom to call and it is difficult to get appointments.
- The sheer number of patients in need of services. Health Centers don't have enough capacity and resources to serve everyone in need so many centers have waiting lists for services. (One health center predicts one-third of their patients are clinically depressed.)
- Lack of mental health coverage under the Alliance.
- Difficulty in coordinating care with outside behavioral health resources, such as referrals, coordination of care, and getting feedback from CSAs.
- Social worker and case management positions to provide care coordination and disease management are not a sustainable due to lack of reimbursement.
- Struggle to maintain funding and recruit and retain staff for behavioral health programs, especially bilingual staff because of the inability to compete with salaries in the private sector (i.e. counselor costs \$175/hour).
- Billing system within CSAs is arduous and time consuming.
- There is a disconnect between DMH and community health centers, especially with regards to the referral process.

Appendix III.

Cost of Adding a Mental Health Benefit to the DC Health Care Alliance

In order to get an exact cost of adding a mental health benefit to the Alliance, an actuarial study would need to be conducted by the Medical Assistance Administration (MAA). Absent that, the following is a way to estimate the potential cost of the benefit.

In July 2007, the Alliance reported serving 23,383 males and 21,810 females in their program. Of these 45,193 enrollees, 94 percent are between the ages of 19 and 64. Unfortunately, the Department of Mental Health does not have data on the services provided to Alliance patients, so similar patient populations are examined to estimate costs and usage. The Medicaid population exhibits comparable demographics to Alliance patients, and thus we can predict some trends in use. According to data from DC's three Medicaid managed care organizations, for the time period October 2005 to July 2006, the plans spent an average of \$4.48 per member per month for inpatient hospital, outpatient hospital and physician mental health services. Total costs for this period were approximately \$1.4 million; however this does not include pharmacy-related costs.¹ In 1999, nationally, 24 percent of fee-for-service Medicaid beneficiaries aged 19 to 64 used psychotropic drugs.² If this number transcended to Alliance patients, over 10,000 would be in need of such medications, but without the means of acquiring them.

Cost Savings

The mean mental health/substance abuse hospital stay is \$7800.³ As with medical care, providing access to basic mental health prevention and treatment services will reduce emergency room and hospital costs. Because of the lack of mental health coverage, Alliance patients who suffer from mental health issues present in the emergency department where services are much more costly. Covering patients with basic mental health services would drastically reduce unnecessary emergency room use and promote care management instead of a wheel-and-flare approach where patients with no option for care must fall to the point of crisis before receiving any health services.

1. Medical Expenses PMPM for the DCHFP Population. Information submitted by the Medicaid managed care organizations.
2. SAMHSA. 1999. Mental Health Services in Medicaid; All States. http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4145/All_States.pdf
3. AHRQ. HCUP. *Care of Adults with Mental Health and Substance Abuse Disorders in US Community Hospitals, 2004*. January 2007

CHC: Community Health Center - non-profit health care centers that provide comprehensive primary and preventive to individuals regardless of their ability to pay.

CSA: Core Service Agency - a mental health provider who has contracted with the Department of Mental Health to provide mental health services to District residents. A CSA is to serve as the "clinical home" for their clients, which means it is accountable to each person it serves. A CSA must ensure the necessary services and supports are provided to promote adults' recovery from mental illness and build resiliency in children and youth to help them reach their full potential.

Dixon Court Order: In December 1975, the District Court ruled that individuals subject to the Ervin Act have a statutory right to treatment in the least restrictive setting, including placement in alternative community facilities when treating professionals have determined such treatment is appropriate. Following negotiations among the parties, the Court issued a consent order establishing a Transitional Receivership starting April 1, 2000. The Transitional Receiver was charged with developing, in consultation with the parties, an integrated, comprehensive and cost-effective community-based plan for the provision of mental health care in the District (the "Plan"). The purpose of this Plan is to provide an overall policy framework for meeting the Dixon mandate to develop and implement an effective and integrated community-based system of mental health care for consumers in DC.

DMH: Department of Mental Health - DMH was established as a Cabinet-level department in the District of Columbia in 2001. The goal of the DMH is to develop, support, and oversee a comprehensive, community-based, consumer-driven, culturally competent, quality mental health system. The agency provides comprehensive mental health services to adults, children, youths, and their families. The DMH also evaluates and treats individuals referred through the criminal justice system.

MHRS: Mental Health Rehabilitation Services - The MHRS system is based on individual services and supports that meet standards set for quality, accessibility, timeliness, accountability, cost, and location. The services include diagnostic/assessment services, medication, counseling, intensive day treatment, crisis/emergency services, and specialized services for adults and children. Supports include rehabilitation programs, residential and housing assistance, peer supports, and family/home-based alternatives to facility-based care.

MAA: Medical Assistance Administration - MAA is the state agency responsible for administering Title XIX of the Social Security Act, the Medical Charities program, and other health care financing initiatives of the District.

SED: Serious Emotional Disorder - An SED disrupts the daily functioning of children in the home, school, and community and affects one in ten young people nationwide. The suspected causes of serious mental health disturbances are complicated and are attributed to the combination of biology and environment.

SPMI: Serious and Persistent Mental Illness - Severe mental illnesses are brain disorders that can be treated and managed effectively if an individual has access to a combination of medication, supportive counseling and community support services. SPMI is caused by psychological, biological, genetic, or environmental conditions.