EUGENE S. FARLEY, JR.
HEALTH POLICY CENTER
A Collaboration For Studies In Primary Care

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Senator Gelser and members of the committee:

I am writing in support of two bills that have recently been proposed in Oregon. Specifically, Senate bills 831 and 832 have the potential to permanently positively influence the entire healthcare culture in Oregon. As the Director of the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine, the following testimony is in response to these two bills and the implications they can have on the people of Oregon.

Together Senate bills 831 and 832 represent a fundamental departure from the standard view of healthcare. Specifically, they highlight a need to better integrate care. Before I respond to the specific bills, please allow me to set context here as to why this issue matters so much.

Primary care, as the largest platform of healthcare delivery, is the ideal setting to focus our attention in health policy and healthcare redesign. Primary care also just so happens to see more mental health than in any other healthcare setting.

But this idea is not new. In 1996, the Institute of Medicine reported that mental health and primary care were inseparable and any attempts to separate the two lead to inferior care.

If fragmentation in healthcare is the problem, there is no greater, more egregious example of fragmentation than in the false dichotomy that the mind and the body are separate. There is also no better solution than integrating care.

We know that the vast majority of individuals diagnosed with a mental health, behavioral health, and/or substance use disorder do not receive treatment; and, if they do receive treatment, most do so in a primary care setting. Consider that one in every four individuals in the United States will have a diagnosable mental health condition in a given year, and upwards of 80% of those with behavioral health disorders visit a primary care setting at least once a year. Yet, the traditional primary care setting is not optimized to provide comprehensive behavioral health care. Integration is the answer.

Oregon, through its innovative work in Care Coordination Organizations (CCO), has highlighted the importance of integrating behavioral health and primary care. However, in our experience, many efforts to integrate fail because they are not all operating from a consistent definitional framework. Said differently, if integration is not clearly defined, it will be hard to measure and to scale across all the CCOs.

As the data show, there needs to be a behavioral health provider working in primary care to achieve the optimal outcomes for patients. To this end, **SB 831**, requires Coordinated Care Organizations (CCOs) to either employ or contract with clinical mental health professionals—psychiatrists, psychologists or licensed mental health professionals regardless of where the setting in which they practice to help enable integrated care. This bill accomplishes two things simultaneously.

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First, it *increases the available provider pool* for mental health providers to work in primary care. Second, it *develops the future workforce* by allowing post Master's level providers who are working toward licensure to get the experience they need to be independent providers in a sustainable way under appropriate supervision.

The second piece of legislation, **SB 832**, further lays the foundation for the provision and expansion of mental services by CCOs. First, the bill adopts the Agency for Health Research and Quality's (AHRQ) definition as follows:

"Integrated behavioral health care" means care provided to individuals and their families in a patient centered primary care home by licensed primary care and behavioral health clinicians along with other care team members working together, to address one or more of the following:

(a) Mental illness;

(b) Substance abuse disorders;

(c) Health behaviors that contribute to chronic illnesses;

(d) Life stressors and crises;

(e) Developmental risks/conditions;

(f) Preventative Care;

(g) Stress related physical symptoms; or

(h) Ineffective patterns of health care utilization.

As the principal investigator on the AHRQ work that has helped create this definition, I can say that its inclusion increases Oregon's ability to standardize what integration is and isn't for the CCO, increase the recognition that mental health providers working in primary care can (and should) address issues far beyond just mental health, and encourages a team approach to care delivery.

In addition, **SB 832**, removes several barriers to care by creating the following:

No wrong door for care: Allows patient-centered primary care homes (as defined by the OHA) to bill for mental health services provided in primary care and urgent care settings;

No wrong code for care: Allows providers to use the appropriate mental health or health and behavior code as the situation warrants, regardless of setting; and,

No wrong license for care: Allows licensed mental health providers to provide care without being in a certified mental health setting.

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It is important to note that this Bill also:

Creates a position on the OHA-appointed Metrics and Scoring Committee that will adopt outcome and quality measures specific to the provision of integrated behavioral health services offered by CCOs;

Creates a Quality Incentive Metric to help CCOs stand up and provide integrated behavioral health services;

Requires agreements between CCOs and publicly funded providers for the provision and management of both point-of-contact and mental health services;

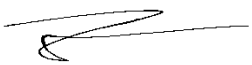
Requires the Oregon Health Authority (OHA) to provide grants to eligible CCOs to integrate mental health and physical health services. Beginning July 1, 2015, the OHA would receive $1 million in general funding to provide these grants; and,

Prohibits CCOs from restricting members' access to mental health services.

As someone with a great deal of experience in the field of integrated behavioral health and primary care, I can say that these companion bills have the potential to be modeled by other states for similar reasons. You see, integration is not a special model nor is it a new thing; integration is all about giving the patients in our communities what they have been asking for. Integration is about good care, and allowing patients to have access to mental health services in the setting they most often seek it. These bills support this notion, and rapidly advance, through policy, mature and sophisticated steps to ensure that what integrated efforts are implemented in CCOs abide by a common definition and work to change the fragmented culture in healthcare.

Our inability to properly address behavioral health in an effective and efficient manner is costing us all. As Oregon works to continue to decrease costs, improve outcomes, and enhance the patient's experience, addressing behavioral health will be central to any effort. These two bills take target at that need and offer a promising solution to help move Oregon forward.

Sincerely,



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