Testimony of Dennis Freeman, Ph.D.
CEO, Cherokee Health Systems
Senate Labor-HHS-Education Appropriations Subcommittee
Hearing on "Mental Health Care: Examining Treatments and Services"
February 15, 2017

Chairman Blunt, Ranking Member Murray, my Senator Lamar Alexander and Members of the Subcommittee,

It is an honor to be asked to share my views on behavioral health service delivery with you today. I am Dennis Freeman, a psychologist and Chief Executive Officer of Cherokee Health Systems, a community health organization in Tennessee. Cherokee is both a federally qualified health center and a community mental health center, and in 2016 we served more than 73,000 patients in 24 locations spanning 13 counties and inner city Memphis.

Before I share my perspective on today's topic, I briefly want to acknowledge and recognize the depth of support that has been shown by this Subcommittee, on a bipartisan basis, for community health centers. Thanks to that support, today some 1,400 health center organizations serve more than 25 million patients in nearly 10,000 communities nationwide. The investments you've made have had a profound impact on the patients and communities we serve, not to mention the healthcare system as a whole, and for that we are truly grateful.

At Cherokee we have blended behavioral health services into our primary care clinical model and embedded behavioral health professionals in our primary care teams for many years. This approach to care is known, of course, as integrated care. Today, I hope to share insights gleaned from our experience in providing integrated care, a model of care that is rapidly gaining traction across the country.

Without question access to appropriate and timely care is the greatest challenge facing the mental health and substance misuse treatment sectors of the nation's healthcare system. In our experience providing access to behavioral health assessment and intervention within primary care goes a long way toward reducing the access barrier to behavioral healthcare so prevalent across the country. Many Federally Qualified Health Centers, as well as other primary care practices, have developed or are beginning to develop integrated practice. Health Centers, who provide primary care for Americans who reside in underserved urban and rural communities, provided 8.3 million behavioral health visits in 2015, almost a threefold increase over a ten-year period.

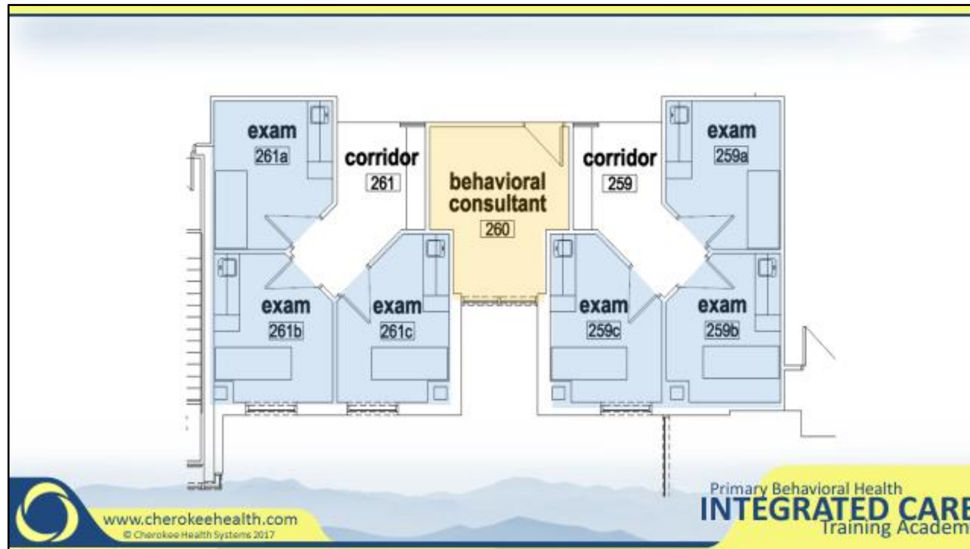
The Expansion of Integrated Care

Primary care is the front door to the health care system. It's the primary access point for all healthcare concerns and medical conditions, including behavioral health issues. In addition to the frequent presentation of psychiatric conditions and substance use disorders in primary care, the personality and the lifestyle of the patient are always factors in a patient's healthcare outcomes. Personal health habits, a history of trauma and resiliency in response to stress all influence the etiology, the response to treatment and the prognosis of all medical conditions presented in primary care. The patient's behavioral health is a factor in every primary care patient visit. This is especially true for patients coping with chronic medical conditions. Encouraging these patients to adopt appropriate health behaviors is the key to the medical management of patients with complex and chronic conditions.

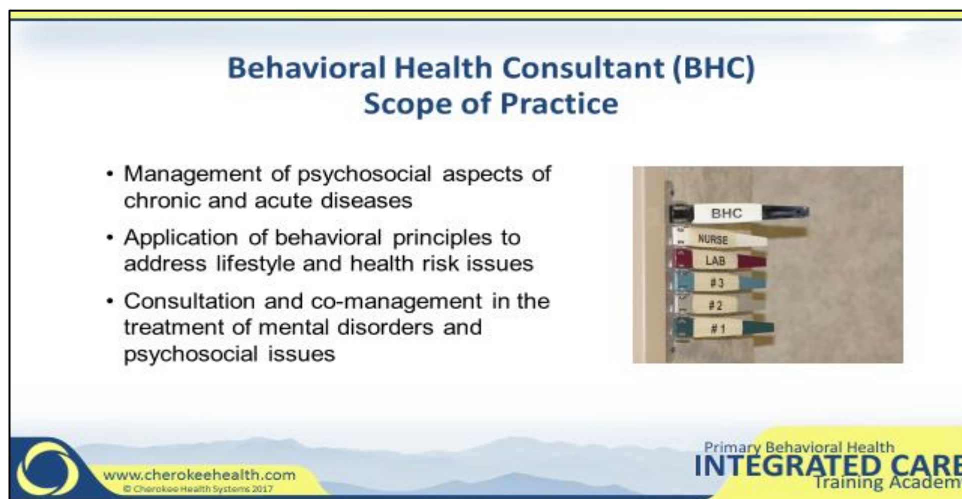
Cherokee's integrated care model developed from efforts initiated over 40 years ago to reach out and bring mental healthcare to residents of the southern Appalachian Mountains in east Tennessee. Circuit riding mental health professionals established a beachhead in rural primary care practices and began sharing care with primary care colleagues. The benefits of this collaboration of professionals was immediately apparent. The experience was profoundly eye opening. It was apparent that the nature of primary care practice was, in large part, behavioral. We learned that most folks turn to their PCP in times of trouble. We watched our physician colleagues counsel their patients through the difficult times in their lives. We observed the impact patients' behaviors had on the outcomes of their chronic medical conditions. A different model of behavioral healthcare began to take shape, behavioral care provided within the context of primary care. In addition, the presence of behavioral health professionals within the primary care setting brought a clearer focus on addressing the psychosocial factors which influence health status. This new integrated care strategy broadened the scope of primary care and enhanced the effectiveness and efficiency of primary care practice.

Description of Cherokee's Integrated Care Clinical Model

Over the past few years the Patient-Centered Medical Home (PCMH) model has come to be considered the best practice when it comes to primary care delivery. At Cherokee we have embraced this model and have enhanced it by embedding uniquely skilled behavioral health professionals, referred to as Behavioral Health Consultants (BHC), in the primary care team. BHCs are available to their primary care colleagues for consultation at the point of care. They provide assessment and intervention with patients during their primary care visit. When indicated, psychiatric consultation is also available, in real time, to the primary care team. Psychiatric consultation is one of the telehealth services Cherokee makes available across its network of clinics.



BHC's have a broad scope of practice within primary care. Not only are they the experts on the team with respect to psychiatric disorders, they also help address the general health concerns of patients. They help patients improve their self-management of chronic medical conditions like diabetes, hypertension and asthma. They also engage patients in adopting healthy lifestyle habits including exercise regimen, diet and sleep hygiene. They help patients stop smoking, manage stress and curb overuse of alcohol and the misuse of other drugs. And when psychiatric emergencies present in primary care, as they did so frequently do, BHC's help manage crises and triage patients into more intensive levels of care when indicated.



When a patient sees a BHC during a primary care visit at Cherokee they generally do not perceive their time with the BHC as a separate session with the behavioral health professional. Much as lab and x-ray are expected components of a primary care visit so is a consultation with the BHC or psychiatrist an expected part of a primary care visit at Cherokee. These embedded behavioral health professionals do not carry an independent caseload. Their caseload is the combined panel of the PCPs with whom they are working on a daily basis. All providers on the team share an electronic health record, treatment planning and the responsibility for the overall care of all the patients on the panel.

The core elements of the clinical model described above have been in place at Cherokee since the early circuit riding days of nearly 40 years ago but the role of the BHC has evolved significantly over time. Currently BHCs utilize well-developed clinical protocols and behavior change strategies, developed over years of practice, to assess and provide therapeutic interventions with patients across the lifespan and with a wide range of medical and behavioral disorders. Like their primary care colleagues, they are prepared to work with anyone who enters primary care. Yet, despite this generalist orientation, there are certain subpopulations of patients with conditions that need a special focus and attention by the team.

For example, the current epidemic of opioid abuse has prompted Cherokee to form a complex care team to serve these patients. We have developed a team-based model to care for women who are pregnant and abusing alcohol and drugs. We seek to become the healthcare home for these patients, just as we are the medical home for patients enduring diagnoses of serious mental illness and other chronic conditions. The integrated medical home is ideal for the care of patients with these challenging and complex conditions.

Cherokee Health Systems has utilized this model of integrated care in our clinics since 1984. It has enabled our organization to thrive through good economic times as well as more challenging times. We have expanded our footprint across east Tennessee and last June added 3 clinics in inner city Memphis. We operate 24 clinic locations and have an additional 24 School-Based Health Clinics where Cherokee primary care providers teleconference in to treat ailing students. Last year we provided care to 73, 965 Tennesseans. 49% of our patients saw a behavioral health professional as part of their care. All benefited from a care team that has incorporated behavioral principles into the pattern of practice. Our patients appreciate the comprehensiveness of the integrated care model. Our primary care providers are enthralled with the support behavioral staff provide them. The integrated care team lightens the individual burden of primary care providers and enhances their satisfaction with their work. Insurance companies are pleased because the overall cost of care declines. Best of all patient outcomes improve.

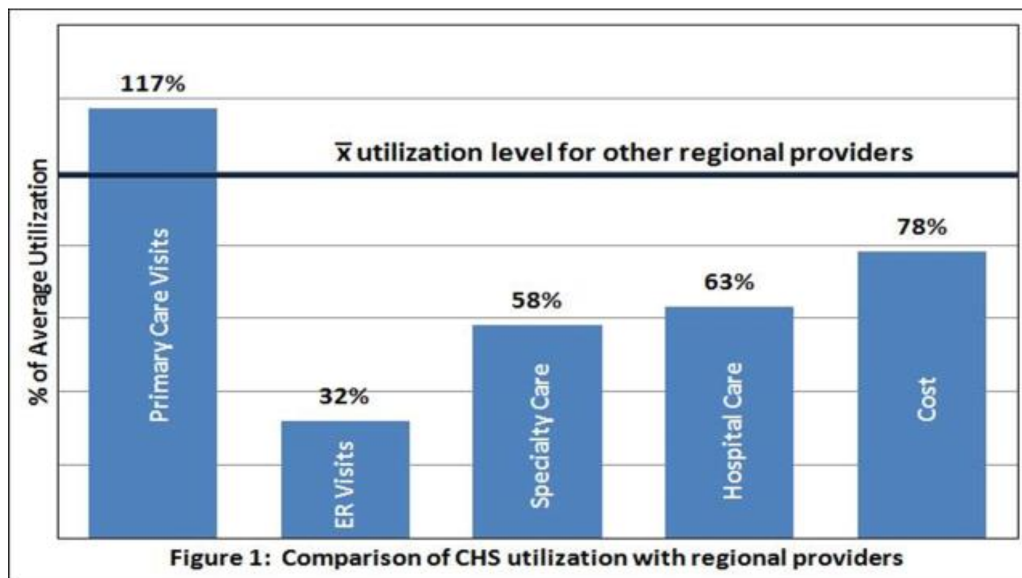


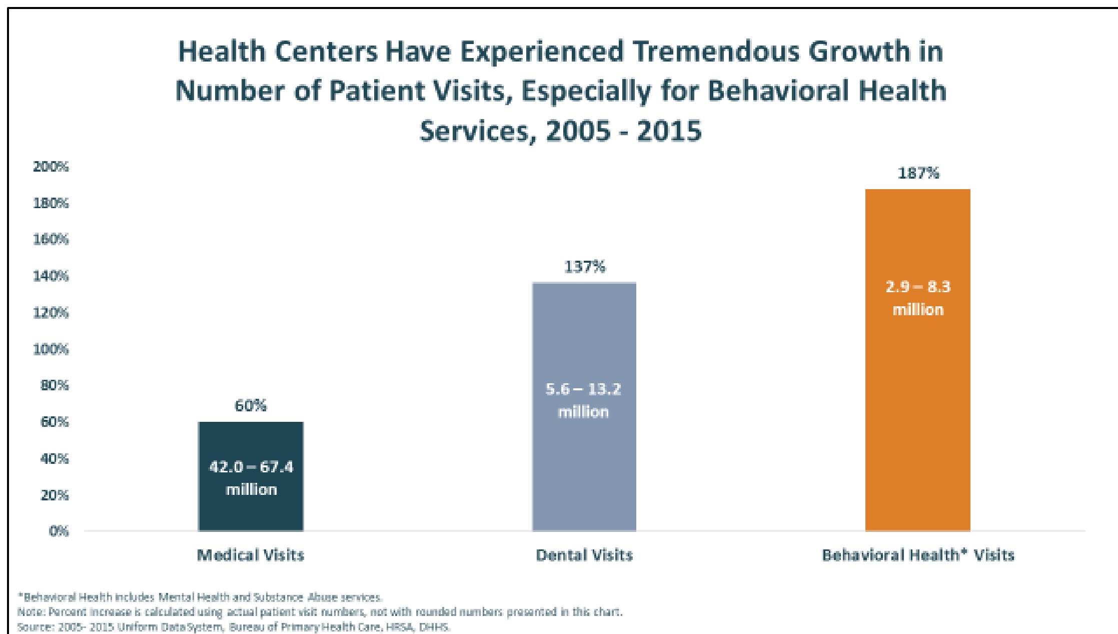
Figure 1: Comparison of CHS utilization with regional providers

The claims cited above are supported by Cherokee's performance data, however, they are not unique to Cherokee. We hear about similar improvement in outcomes when the integrated model is deployed from colleague organizations who attend our Integrated Care Training Academies. The professional literature provides abundant support for integrated care. The Agency for Healthcare Research and Quality (AHRQ) began taking a keen interest in integrated care a decade ago. In addition to reviewing the research support for integrated care AHRQ has produced a definition of integrated care and supported a study of the best practice of integrated care.

Policy Recommendations

The system of providing behavioral health care, especially truly integrated care, is complex. It varies state to state, and community to community. Still, there are several areas of policy – both within the Subcommittee's jurisdiction and related to it - that I want to highlight.

The Federal Health Centers Program has been instrumental to efforts to support and expand care integration at community health centers nationwide. In recent years, with funds allocated by this Subcommittee and the mandatory Health Centers Fund, HRSA has made important, targeted investments to expand the health center system of care. At your direction, these funds have not only gone to fund new health center sites, but to expand services, with a particular focus on mental health and substance use disorder treatment.



One of the most impactful recent investments has been the funding provided in the last Fiscal Year to expand health centers' response to the opioid epidemic. These funds have helped establish and support the dedicated care team I described earlier, focused on patients struggling with opioid use.

As members are aware, without Congressional action by September 30th of this year, Health Centers nationwide face a 70% cut in grant funding with the scheduled expiration of the Health Centers Fund, which was extended for 2 years in 2015 on a bipartisan basis. Nationally, HHS projects that a reduction of this magnitude would mean the closure of more than 2,800 health center sites, loss of some 50,000 jobs, and most importantly, a loss of access to care for some 9 million patients in need. At Cherokee we project we would be able to care for 10,00 fewer patients and 80 staff positions would be in jeopardy. While I recognize that members of this Subcommittee only allocate a portion of CHCs' overall funding, I ask that you work in concert with the other Committees of jurisdiction, with the House and with the Administration to avert this cliff and indeed to make strategic new investments in health centers.

One additional challenge that faces organizations like mine across the country is the ability to train, recruit and retain a clinical workforce. We grapple not only with the issue of shortages in both primary care and behavioral health professionals, but with finding those professionals who are prepared and eager to practice in a truly integrated care environment. For this reason, I do want to highlight the importance of two smaller programs – the **Graduate Psychology Education Program** and the **National Health Service Corps** program. The GPE Program supports the inter-professional training of doctoral-level psychology interns and postdoctoral fellows while also providing behavioral health services to underserved populations such as older adults, rural populations, children, those suffering from chronic illness, veterans, victims of trauma and abuse. The Corps creates a vital incentive for clinicians – including behavioral health professionals – to enter primary care and to practice in rural and underserved areas. Nationally, more than half of NHSC clinicians practice in health centers. Cherokee has benefitted greatly from both of these vital programs.

While grant funding, whether it be operational support or targeted support for recruitment or training, is critical, I do want to underscore that grants alone cannot create or sustain the systems of care we need in order to properly serve our patients. For the patients served by safety net providers like FQHCs – and CMHCs – **the importance of the Medicaid program cannot be overstated.** Nearly 40 percent of the patients we see at Cherokee are covered by Medicaid – nationally, Medicaid covers nearly half of all health center patients. Unlike many other forms of public and private coverage, Medicaid typically covers important behavioral health services, further driving the move toward integrated care. And because Medicaid was designed to work with health centers through a unique prospective payment system, health centers in particular can leverage Medicaid resources effectively into patient care that saves the taxpayer resources long-term.

Not only does Medicaid provide value for health centers, but we strongly feel that by delivering primary and preventive care before it becomes more acute, health centers also deliver enormous value to Medicaid, and, by extension, to the federal taxpayer. A recent study showed that when compared to patients who received their primary care in other settings, health center Medicaid patients had 24% lower total costs of care. Nationally, health centers serve one in six Medicaid beneficiaries for less than two percent of the overall Medicaid budget.

Conclusion

I commend the Subcommittee for today's examination of mental health services and treatment, and the impact that these services have on patients, communities and the entire health system. As you continue your work, I urge you continue to **support primary care as an efficient and effective platform for the delivery of behavioral health services**. Our experience at Cherokee, and similar experiences around the country, have demonstrated that this model works. In supporting this work, I urge you to look beyond mere co-location of behavioral health and primary care, but to focus your support on driving truly integrated practice.

I recognize that you have difficult decisions to make, competing priorities and a difficult budget environment. As you examine these choices in the year ahead, please continue to prioritize investment in operational capacity, workforce development and meaningful coverage – all of these components are necessary to build a truly integrated system worthy of our patients and their diverse needs.