CEO Leadership Series: Vol. 8

Behavioral Health with Janice Pyrce

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SCALE's Co-Founder & CEO, Roy Bejarano, had the opportunity to meet with Janice Pyrce, SCALE's Executive Partner, Behavioral Health, to discuss:

1. How the industry has changed over the past 40 years
2. How physician groups are integrating behavioral health into their platforms
3. The impact of government policy
4. Considerations to make when investing in the space

Janice Pyrce was clinically trained as a psychiatric social worker at the University of Chicago. She received her MBA from Northwestern while working at the **Hospital Corporation of America** as Senior VP for Business Development. She joined the company's Psychiatric Division following its acquisition of a med-surg company that had 19 psychiatric hospitals. She was part of the team that built and bought that entity to a 53-hospital platform.

From there she launched **Pyrce Healthcare**, her own consulting practice, where she has brought her expertise and insights to dozens of both non-profit health systems and for-profit clients including private equity-backed and publicly traded organizations.

Her work has focused on behavioral health focused strategy and business development, including business growth, mergers and acquisitions, integration, restructuring, and working with investors on business due diligence.

Jan, how has the behavioral health category evolved over your career?

I've seen the world of behavioral health in two eras: pre-Managed Care and post-Managed Care, and now there's a new emerging era of Integration and Value, as both payers and providers acknowledge the comorbid relationships between mental health and medical conditions, a common example of which is a 30-day medical or surgical diagnosis readmission due to a non-compliant or undiagnosed mental health problem.

There was historically a massive gap between medical care and behavioral health to the point where they were almost entirely disconnected. And now we're starting to see convergence again, largely around payment reform. It's not grounded in a sense of, "Oh, we want to treat the whole person." It's really driven by the fact that there's now going to be accountability for patient behavior that may be tied to behavioral health conditions. Is this consistent with the trends that you've seen?

Yes I think clearly the reimbursement trends help push and drive innovation, for sure. As an example, The University of Washington, the AIMS Center developed a collaborative care model. An example of a recent ground swelling in new model development focused on how to provide collaborative care, for example behavioral health combined with basic primary care.

There's been some really nice work in the field in developing some of these new models that really weren't there in a way that solve

for behavioral health screening, how to really have an evidence-based model, how to continue to work with the population until there really is problem resolution. So that's been very exciting. And that's probably been in the last maybe five years.

Are we seeing, Jan, an improvement in results, empirical results, clinical results that correspond with the change in how we think about behavioral health with our broader health ecosystem? You mentioned more home care related behavioral health, different combinations of inpatient outpatient solutions, different medication components, more or less, how is the science changing and how is that manifesting in results?

Let me offer two answers. In the collaborative care model, let's use the AIMS model, they actually recommend using PHQ-2 instruments as well as PHQ-9, and then continuing to administer until the patient demonstrates a positive clinical outcome. So again, that's relatively recent. And what's nice is that the new models being rolled out in different geographies are using the same tools/structure, using the same PHQ-2, PHQ-9 standards, so you can actually draw comparisons between different settings.

One of the challenges in behavioral health, while there's always been interest in outcome, there's not necessarily been standardized outcome tools. So we used gap measurements for instance at one point, and then the last DSM was revised. Providers historically performing follow up interviews, over say 12 months. And then we try to assess outcomes based on their self-reports of patient behavioral change spanning months if not years. That's been very hard to analyze from patient to patient, and from provider to provider.

And so, the question has historically been really, how do we really just find a positive outcome and what does that look like and how do we monitor it? But I think what we now know in a lot of behavioral health and in a number of diagnostic areas, let's take eating disorder, I do a lot of work in the eating disorder arena. I think many of the residential treatments programs would suggest to their patients that they will be on a lifelong recovery path, that they will leave the program, but they'll need to be aware of self-care on an ongoing basis and may need different types of support services. It could be everything from continued medical management, maybe self-help groups as well, but that the outcome is based on staying on a recovery path over many years. The goal is not necessarily 100% problem resolution in a fixed moment in time.

It appears to me, Jan, that behavioral health has been bucketed in a paradigm that feels a little antiquated, which is the paradigm of episodic care and maybe the whole industry suffered as a result. Whereas, behavioral health, unlike other specialties that we focus on is so heavily entrenched in the model of continuous care? And the many facets of continuous care that are both good and bad. One of the challenges of continuous care models is the pressure and the need for constant information flow and the operational infrastructure to support that? Multilayered ecosystems talking to each other continuously over time. But it does seem to me that the world that we're moving into with data becoming a lot more available, is more conducive towards creating infrastructure that can really support long-term behavioral care solutions.

Yes, I think we have made some really great progress. And when you talk about societal well, there's a lot of levels and layers to this. When I think about when I started out in the field in the 1980s, there's clearly been improvements in addressing the stigma with helping individuals both acknowledge and receive help. Early on it was Betty Ford coming forward and there's been other individuals who have stood up and shone a light. Let's be real, if we look at it from an epidemiological standpoint, one in four adults have a diagnosable mental health problem on any given day – that's our brothers, sisters, friends, cousins, workmates.

So the prevalence is huge, but no one really thinks it's going to happen to them or anyone they know. So working with this stigma, trying to normalize that behavioral health is something that's there, and there are increasingly effective treatment options, and it's okay to talk about. I mean, this is at a broad level. It's still really important. Then more recently, we've had some mental health party legislation, which coming back to the reimbursement side, ensures that a health plan will have behavioral health benefits that are on par with standard medical benefits.

And so that, as well as some components of the Affordable Care Act have really helped support individuals who want to use insurance to be able to access mental health services. When you look at the research on, less than half of the individuals with mental health issues actually receive formal help. So why is that? One answer is that large numbers don't know where to go to get help. Some of that is again the stigma because we're afraid to ask. And then there's a group who feels that somehow they couldn't afford it and don't understand the financial structure.

...There are still those barriers out there, but we clearly have made some improvements. And there's some good, I think, tailwinds with the mental health parity legislation and the Affordable Care Act.

One of the things the Affordable Care Act did, which again, you'd have to think like a behavioral health person to think of the implications, it said that young adults can be on their parents' insurance until age 26. Well, what we know about major mental illness is that it'll often present in the early 20s. There's probably indications with many of those individuals in their late teens, and so it would just present itself at a time that a young adult is transitioning to their own insurance or opting out of insurance all together. If it's on the young adult to get purchase insurance, they might mislabel themselves as healthy, opt out of insurance and then go through major episodes without any professional help. So, I've seen in my work in Eating Disorder, a lot of the patients I work with are young women, in their 20s, now able to continue treatment at age 23, 24, g because they're able to be covered under their parents' insurance. And that was a change the Affordable Care Act provided that has really been a positive in advancing mental health treatment forward.

[Behavioral health] is in a really good place in the industry with some evidence-based models, more integration, some improvements with the payers...there is enormous opportunity on the investor side, given all of those really positive tailwinds that we are presently experiencing.

For our readers thinking about this category from an investment standpoint, what should they be excited about structurally, strategically, and what should they be concerned about operationally? Are they better off focusing on balanced assets that have both inpatient outpatient solutions, that have a broad menu of service offerings? Or are the better opportunities really narrow model groups that focus on one service type solution and repeat it almost like a cookie cutter model? And what about market demographics? Should the focus be on the elderly? The young adult, and teen category, or even earlier intervention? Where's the most underserved, highest growth potential opportunity? And also operationally what is uniquely challenging in this space that a group that has historically invested in Derm, Dental, Ortho or Urology wouldn't think to be a challenge until they actually found themselves involved and invested in a business focused on behavioral health?

Well, I think one thing to be aware of when, again coming back to the prevalence and the epidemiology, is that there's still huge demand. So then your question is if there is demand, what's the best way to be in the service area or to be in the business? Most of the organization is on a disorder basis. So with probably the largest grouping of services being in the addictions arena, given the huge demand there. We then have service arenas for example eating disorder programs. There's now some growing kind of management of outpatient, some of those public sector funded. Historically it's pretty much all been insurance funded. So now there's some growth in looking at programs that would be both traditional insurance and Medicaid or Medicare funded.

Investors focused on a behavioral health need to be sure that they're ultimately picking and supporting a business that has a clear definition, a niche that supports their mission. There's a lot of addiction programs and the ones that do well normally have a clearly identified approach to how they're doing what they're doing. So that it can be made tangible and communicated to the markets that they work in. There is much demand, but you can't offer something that's vanilla and expect to be treated well by the broader market place. It's got to be really well defined. There's a social part to this, and obviously we could have a whole social determinants discussion as well. It's probably a little different than other areas of medicine in that many of the referral sources to these programs are, there's a clear B2B component, but they're psychologists and therapists, and other treatment programs, not necessarily all through MDs and health systems.

So the program needs to be defined and there needs to be an understanding on how to build a network in order to have a good strong referral base. Continuous care is good. I mean, historically and it's probably still the case, a lot of the really high margins have been in programs that are bedded, whether they're inpatient or residential. But there have been improved margins now looking at the outpatient ambulatory sector as well, particularly what we call intensive outpatient programs and partial hospitalization programs, otherwise known as ILPs and PHPs, in the field. So the entire continuum is now very important.

I have a follow up question to that, from an integrative practice perspective, what would be some of the assets and resources that a primary care platform would say, "We need to add them to our platform in order to provide a higher level of integrated care to our patients. One in four patients who have some mental health related comorbidity." Is it a knowledge of psychopharmacology? Is it adding psychologists or social workers or behavior analysts?

Well, if you took the AIMS model, for instance, the University of Washington model, which is very well defined in collaborative cares. They have, in fact, staffing models within the primary care practice, that's focused on a case manager position. There's a

psychiatrist there, but the psychiatrist is a consultant. So the first line clinician working with the primary care physician is the case manager who could be an RN or a Master's licensed individual who's performing assessments, using these PHQ-2s, and then working with preliminary recommendations on interventions. The case manager could identify the patient back to the primary care doctor for medication management, could also consult with the consulting psychiatrist to get that patient's recommendation back to the primary care physician.

So it's a partial restructuring of the primary care office. First and foremost at the beginning with the philosophy that part of what we do routinely is identify comorbid mental health issues, and then have a structure to be able to do that assessment and then provide holistic intervention. And again, the consulting psychiatrist could be using a tele-psychiatry model as well. And it's all done there within the practice. Its worth comparing that to historically had been the primary care model. There was at one point a Medicare provision that if you saw a primary care MD, you couldn't see a mental health person on the same day and receive coverage. So right there you get somebody in the primary care office, they need to talk to someone but you tell them to come back another day. Well, what are the odds that they're going to come back because they didn't come to that primary care office because of their mental health problem, at least in their top of line awareness. There's been some reimbursement changes there as well a recognition that we need to do the screening routinely with all patients, and then we have to be able to link the patients with their required care. And so there's really been some exciting progress in that arena.

So given the economic side of this, what would be some of the counsel you'd give to a provider network that wanted to expand into a model, into a more integrated model in terms of their negotiation with payers?

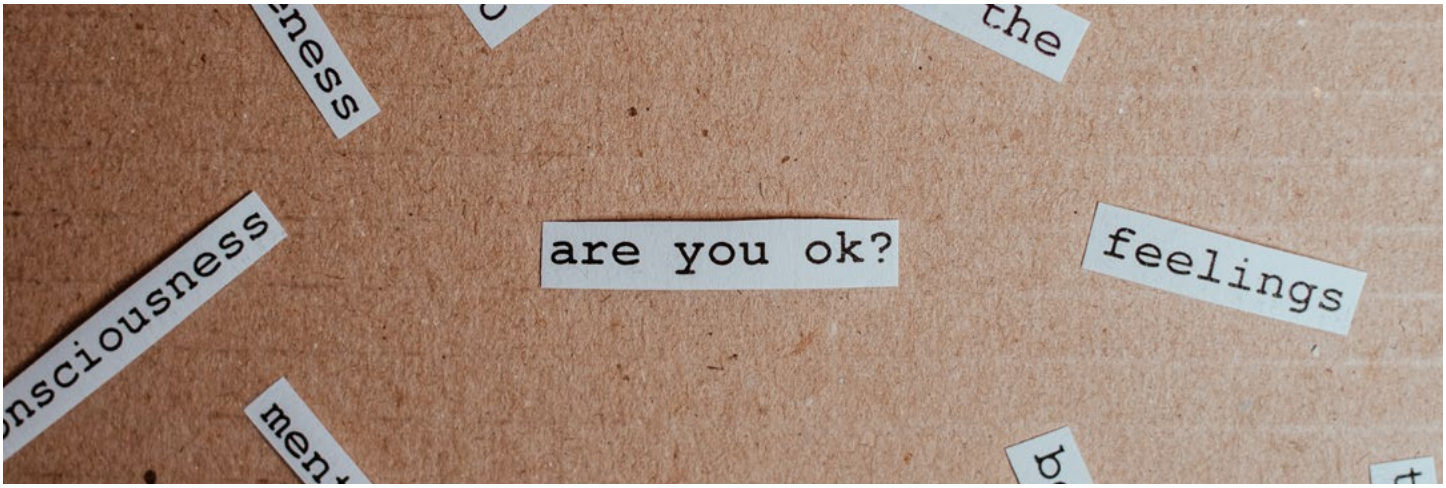
Well again, it would depend on the payer and what was available. I mean, certainly being able to perform early identification, it depends on what the point of view is. If we're talking about the hospital level, doing early identification and intervention certainly would strengthen your discussion with payers about reducing readmissions, short term readmissions. And then of course, from a longer term management perspective, again, being sure folks get linked, whether it's coming from the hospital or coming from a primary care office, with needed services so that they have those resources.

The right resources early on eliminate a readmission at a higher level of care. Trying to get folks using a level of care that would be more ambulatory and knowing what those resources are on an ongoing basis.

So there's an educational piece in particular like this in the AIMS model, that coupled with an integrated behavioral health system can help ensure patients know how to get care sooner, have earlier interventions, all of which from an insurance standpoint, offers meaningful cost savings.

But there is a negotiation piece. And I only say this because one of my colleagues has a pediatric practice out on the East end of Long Island and she's actually brought a psychologist into her practice. It's a pediatric practice. She went and she's in network with Aetna, but she went to Aetna to try to negotiate rates around this integrated care and Aetna actually simply said to her, "No, we've carved out behavioral health to Beacon. You have to become a member of the Beacon network. When she looked at the Beacon, the terms of being in the Beacon network, it actually inhibited her ability to do integrated care for patients. So through one of my Aetna relationships, I escalated her to the CMO level for the region and she's actively negotiating. But, I think a lot of practices don't necessarily have the means to escalate their needs with payors. In this case, she thought she was just getting the denial.

Well that's a classic example. And again the insurers, are not monolithic. I mean you take Horizon, Blue Cross in New Jersey, I'm working there, they're actively looking at building an AIMS integrated model and pushing the health systems and saying they want to reimburse for that. That's not true for all payors, its case by case. So sometimes it may come in some markets from the payers and sometimes, as you're describing, it may come from the providers who will have to escalate it with their local payers.



And there's a lot of unevenness in the payer community? I'm thinking back to the practice I was in, we were in 14 States. I was with the MSO. We had 14 States, 42 offices around the country. We didn't have a specific behavioral health strategy. We did have a behavioral health nurse practitioner and psychiatric nurse practitioner who worked at the network level and was accessible to all of our primary care physicians. Again, large platform, 50,000 patients in the network. What's the opportunity for such a group both in terms of the practice itself as well as perhaps relationships for more acute care services?

That's a great example. I think the structure within the practice again is building this collaborative care model. Ensuring you know that there's screening being done, PHQ-2s, 9s, what happens if somebody is identified in need of service based on the screening tool, how to get that person linked with help. And then also at the payer side, being able to demonstrate what the model is, how it's evidence based, what the implications are in terms of well-being as well as in terms of overall patient care costs to the payer, to be able to negotiate the types of coverage with the particular payers that service that area.

Across your many states you dealt I'm sure with Blue Cross, Aetna, Cigna, United Optum. I mean, the four who all have varying types of initiatives. We've probably seen a little more innovation with some of the Blue Cross plans, some with United Optum as well, a little less, (unless as you described you escalate) from Cigna and Aetna.

Well again, our group already had some expertise on cohort based special needs, cohort-based negotiation. So I wish we had had this conversation before. I will tell you, the AIMS team structure would have served us very well at the primary care level. We had the person but we didn't utilize and present their services in the way that this illustrates here.

Well, again, I come back to the one in four adults have a diagnosable mental health problem and I'm an advocate for helping individuals get help. And I think we are in a really good place in the industry with some evidence-based models, more integration, some improvements with the payers. So I think that there is enormous opportunity on the investor side, given all of those really positive tailwinds that we are presently experiencing.

Special thanks to Janice Pyrce for her insights and our Executives for their participation in this discussion.