August 23, 2021

Senator Ron Wyden and Senator Mike Crapo
United States Senate
Committee on Finance
Washington, DC 20510-6200

RE: **Response for cited input to your Mental Health Letter policy requests dated August 5, 2021**

Dear Senators Wyden and Crapo,

After reviewing your August 5th letter to the Senate Finance Committee Members, it is clear you both are well-aware of the fiscal and human costs of failing to deliver timely, efficient, and effective mental health care to Americans. We would like to propose a fiscally responsible solution to the mental health crisis that directly addresses the stated goals in the letter, starting with the highest risk and cost and least accessible patient group, the chronically ill seniors. The system is administered by Behavioral Response Evaluation Program Administrative Services, BREPAS, website, www.BRESystem.com.

The Behavioral Response Evaluation Program

- Directly addresses behavioral health workforce shortages by allowing treatment for mild to moderate cases without the need for mental health specialists and separating out physician-only tasks from tasks requiring less specialization and/or less existing office staff support to administer
- Expands access to high-quality mental health care services while targeting high-risk groups, resulting in lower overall healthcare costs, improved patient outcomes, and increased efficiency
- Allows patients to be evaluated and access care in the most appropriate settings, before the identified mental health maladies become emergent or life-threatening and before significant morbidity has occurred
- Enables care integration and coordination with low to no-cost community resources that have been repeatedly and empirically shown to improve and maintain mental and cognitive health
- Allows historically underserved communities to access basic mental health care for mild to moderate cases through regularly seen Providers, with mental healthcare specialist referrals used only for severe cases

The BRE program has already worked successfully with thousands of patients over the past 2 ½ years. The program employs dedicated and trained leased-staff members to work in physician offices or by telemedicine. Currently, the program targets patients with chronic illnesses over age 65 with Medicare benefits. It offers a combination of depression, addiction, and cognitive health evaluation and testing with comprehensive treatment and follow-up via direct interaction with patients via telehealth and in-person and documented follow-up plans for simplicity of implementation. The dedicated and leased staff provided by the BRE Team manages and implements all the non-physician dependent elements of the program, making psych and neuropsych services fit seamlessly into a physician's office without further stressing the known workforce issues. In addition, the Program's framework allows for existing diagnosis and procedural codes that are already covered under most Medicare policies across the country. Testing includes gold standard measurement tools to identify and measure depression, suicidality, drug and alcohol abuse, and, critically, cognitive decline and dementia due to any cause, including Alzheimer's Disease. However, because of many State policies and fee reimbursements, the same is not true for access to Medicaid patients.

BRE staff directly connects the patient to community-based resources and ensures that the resources are appropriate to the patient's individual needs and accessible to them, as well as periodic follow-up to encourage participation. For instance, a physician-approved treatment plan might include BRE staff helping the patient join a walking club and a smoking cessation or addiction support group, in addition to other lifestyle modifications and medical treatments. The BRE staff member would ensure that community events assigned would benefit the patient condition(s), and that they had adequate logistical access. Additional follow up from the BRE staff, using telehealth, including in-between office visits, allows the staff to monitor the patient's clinical state, provide motivational support, and receive patient feedback.

Frequently used community-based resources include social, physical, and other programs through local senior centers, Silver Sneakers, walking clubs, special interest clubs (such as birdwatching, chess, knitting, and sports clubs), Meals on Wheels, religious organizations, and houses of worship, volunteering organizations, and addiction support groups such as Alcoholics Anonymous, including digital access during covid restrictive periods.

The continued success of the BRE program relies on two factors. The first is Medicare and Medicaid policy that encourages mental health testing, evaluation, and treatment for chronically ill seniors. In addition, CMS needs to ensure equality of reimbursement when services are correctly supplied and appropriately billed by each participating physicians' office using the BRE EMR mental health platform and process.

Why Focus on Seniors First for Depression, Suicidality, Alcohol and Substance Abuse, and Cognitive Function?

Seniors over age 65, particularly those with concomitant chronic illnesses related to pain and other primary diagnoses, have a high prevalence of depression, suicidality, and alcohol addiction and are susceptible to steadily rising levels of opioid abuse. Furthermore, there is an ever-increasing risk of possible cognitive decline related to increasing age and other medication complications. All of these factors can be detected and corrected before avoidable hospitalizations and the need for institutionalization.

For example, depression is now the third leading disease worldwide. The WHO estimates that it will be the leading cause by 2030. Many necessary medications, including anticholinergics and opioids, contribute to depressive symptoms, which can be more easily detected by the BRE Program and addressed earlier. Additionally, the link between depression and chronic pain is highly prevalent, with an estimated 13% suffering from both conditions simultaneously (Zis P, 2017). Rates of suicide are also higher in seniors, more so than in any other age group (Shah A, 2016).

Alcohol abuse is higher in the Baby Boomer generation than in previous groups and has well-known serious consequences for physical and mental health (Barry KL, 2016). Opioid abuse levels are rising in the over 65 population, despite the commonly held belief that the opioid epidemic primarily affects younger adults (Carew AM, 2018).

The rates of Mild Cognitive Decline and Dementia increase with increasing age. An estimated 10-20% of adults over age 65 suffer from Mild Cognitive Decline, while 13.9% of those over age 71 have some form of dementia, including a subset with the Alzheimer's variety (Alz Demen Editors 2021). Many lifestyle modifications (when prescribed and used) are associated with treatment and prevention of cognitive decline. Early identification of cognitive decline allows for symptom-based medical treatments, identification of side effects of medications, dosages, and interactions, as well as lifestyle interventions that have been shown to slow or improve symptoms.

As has been shown in numerous studies, preventative treatment and treatment early in the disease course is also less costly to the health care system. Early detection allows for more and better treatment options, leading to better outcomes, lower morbidity, and lower mortality. Most importantly, the proper treatment/intervention can preserve living independence which can be critical to both patients' desires as well as costs for assisted and or nursing home alternatives. Intensive hospitalizations and or readmissions can be reduced using such strategies.

Primary care, and other specialties in which the patient is regularly seen, such as Pain Medicine, are ideal venues for identifying, tracking, monitoring, and treating these common conditions, often slowing more rapid decline or potentially eliminating symptoms through early identification of medication side effects, interactions, and dosages.

Why use social and physical engagement and lifestyle changes to support medical therapies?

1. Participation in social and community activities helps prevent the demonstrably negative effects of social isolation, including depression, substance abuse, and cognitive decline.
2. In addition to its well-known cardiovascular benefits, exercise improves mood, memory, and cognition. Exercise also reduces falls in the elderly, a major source of morbidity and mortality in this group. Exercise must be prescribed to the patient's abilities and the types and methods that the individual patient will continue to follow.
3. Dehydration, malnutrition/undernutrition, some causing obesity, are common in the elderly and can lead to declines in mood, cognition, and overall health. They must be identified, corrected, tracked, and monitored.

Greater detail on how BRE meets the specific goals stated in the Senators' Letter

BRE Directly addresses behavioral health workforce shortages by reducing reliance on mental health specialists, both psych and neuropsych, for mild to moderate cases. In addition, BRE delegates many supportive tasks to QHCP supervised leased staff that has been appropriately trained to perform services from each office. The combination of telehealth and in-person encounters makes this efficient and beneficial for optimal cost savings and efficiency.

Physicians can easily incorporate the system into their existing offices and workflow. Assessment scoring and administration are conducted by trained BRE staff with the balance of the evaluation, interpretation, and care adjustments, changes being a collaborative effort. Automation of graphical representation of treatment progress is available for Providers to quickly and effectively track results over time as well as by specific encounters. In all cases, following the evaluation and assessment process based on ICD, NCD, and LCD policy guideline qualification criteria, followed by standardized testing and interaction with each patient, a comprehensive and customized mental health Treatment Action Plan is created by leased staff/doctor collaboration, with final approval by the Provider. Take home treatment action plans can be monitored as part of the process but are also adjusted based on changes in patient condition, seasonality of events, and changes in patient preferences. The end result is higher compliance with a paper schedule given to each patient for the following time element after each BRE-based encounter parameter.

BRE allows patients to access care in the most appropriate settings.

The BRE program makes it possible for mild to moderate conditions to be treated, tracked, and monitored from a non-mental health specialty Provider or other outpatient physician office, reserving psychiatry, neurology, and other specialist referrals for more serious cases or cases where the primary diagnosis is a mental health etiology. This preserves specialist time (workforce limitations) while expanding access to depression, addiction, and cognitive health treatment.

The BRE Program expands access to high-quality mental health care services while targeting high-risk groups to boost time and cost-efficiency. It also allows historically underserved communities, such as those in rural or low-income areas, to access basic mental health care through their regularly seen care providers, with up-rated care referral for beyond moderate to severe cases.

By incorporating the BRE program into a patient's routine visits to regularly seen physicians, generally chronic illness Providers such as pain specialists, cardiologists, internists, geriatricians, et cetera), access to mental health care becomes almost seamless.

As is well known, historically underserved communities, such as in rural and low-income areas, suffer from an even more significant shortage of mental health professionals than the nationwide average. Creating an access point through patients' existing doctors allows these communities to easily receive care and referrals when necessary, providing a gateway into mental health treatment. This can be further supplemented using an expanded version of BRE for telehealth encounters, whereby even greater access can be offered.

Currently, focusing the BRE program on patients aged 65 and over is effective and efficient mainly because of the greater underlying prevalence of mental health disorders, depression, addiction, and cognitive impairments in seniors.

In a recent study performed in 2021, between 11-35% of older adults have clinically significant symptoms of depression, with higher rates reported in clinical settings (Muhammed T, 2021). The relationship between depression and cognitive function impairments is also highly prevalent, so much so that they are regularly found together.

Older adults are also at an increased risk of depression and suicidality. Seniors have the highest suicide rates of any age group in almost all countries globally, and the rate of suicide also increases in people over age 60 (WHO, 2019 and Shah A, 2016). Adding to this age risk factor for depression and suicidality, older adults also more frequently suffer chronic or semi-acute pain, and in addition to worsening overall functioning, depression also worsens chronic pain, as well as many other organic disease processes. "Geriatric depression is a major public health problem and has an especially large effect on health when comorbid with a chronic medical condition. Hypertension, coronary heart disease, and diabetes are accompanied by a high incidence of depression and can affect the treatment and prognosis. Depression is a highly prevalent risk factor for incident of, and is associated with, morbidity and mortality of cardiovascular disease" (Zhang Y, 2018).

As seniors more often suffer from chronic pain, they are also more frequently treated with opioids. Studies have shown that depression occurs in 40% of patients dependent on prescription opioids and that 10% of opioid users will develop depression after just 30 days on the medication. (Scherrer JF, 2021)

Worse still, depression is associated with an increased risk of developing dementia and worse dementia outcomes. The severe and progressive nature of cognitive decline and costs to society and the individual make it critical to address effectively, which means addressing associated and contributing conditions. "Recent research studies found that a depressive disorder is correlated with a heightened risk and acts as a strong predictor of developing true dementia. Depression with cognitive impairment nearly always implies incipient dementia and should prompt the professional to begin a relevant diagnostic workup" (Sekhon S, 2021).

A 2021 cross-sectional study's results provide an excellent summary of the issues. "Depression… is a highly prevalent psychiatric disorder among the older population and is the most frequent cause of emotional suffering in later years of life [5, 6]. Late-life depression (LLD) is a significant public health concern as it leads to functional decline, physical disability, and increased health care usage [7, 8]. It negatively impacts physical and psychological health and quality of life [9, 10]. As per epidemiological data, about 11–35 % of older adults experience clinically significant depressive symptoms [5, 11]. However, these rates are even higher in clinical settings [12]. Depressive symptoms are more frequent among the oldest old population, but the higher frequency is explained by the factors like aging, physical disability, and cognitive impairment [5, 13]. Nevertheless, from a diagnostic perspective, LLD is often under-recognized, under-reported, and under-treated [14].

A growing body of literature suggests that depression is a prodrome to dementia and plays a significant role in the development of long-term cognitive disabilities [15]. Individuals with LLD frequently present with several cognitive complaints in the clinical environment, and it is estimated that 20–50 % of older adults with LLD have cognitively impaired abilities [16, 17]. Depression and cognitive impairment are estimated to co-occur among 25 % of older individuals aged 85 and above [18]. According to Kingston et al. [19], over the next two decades, the proportion of older adults with both cognitive impairment and depressive symptoms will increase." (Muhammad T, 2021)

Alcohol and substance abuse rates are increasing in the elderly but frequently go undiagnosed.

Quotations from several studies by Bary and Carew bear out this point. "A substantial and growing number of older adults misuse alcohol. The emerging literature on the "Baby Boom" cohort, which is now reaching older adulthood, indicates that they are continuing to use alcohol at a higher rate than previous older generations. The development and refinement of techniques to address these problems and provide early intervention services will be crucial to meeting the needs of this growing population" (Bary KL, 2016).

"Problematic drug use (of which opioids make up the largest proportion) had been incorrectly assumed to end as patients age. … Addiction and healthcare services must anticipate and prepare for increased demand by this group" (Carew AM, 2018).

In addition, substance and alcohol abuse are also correlated to cognitive decline. A study published in 2018 found that, "alcohol use disorders were a major risk factor for onset of all types of dementia, and especially early-onset dementia." (Schwarzinger M, 2018 and Topiwala A, 2018)

A*long with medication and/or other interventions, lifestyle modifications, such as improved nutrition and exercise, and community-based/social connection therapies are effective treatments for depression, suicidality, and cognitive decline.*

For example, a 2017 study concluded that "Adding aerobic, progressive exercise to antidepressant drug treatment may offer significant advantages over standard treatment for cognitive abilities and disability. These findings suggest that exercise for older adults may constitute a valid therapeutic measure to improve patients' outcomes" (Neviani F, 2017).

A study published the following year also reported multiple benefits to exercise. "Muscle strength and physical activity are factors positively associated with a better performance on the Rey Auditory-Verbal Learning Test, QoL-AD and Goldberg Depression Scale in older adults with mild to moderate cognitive impairment" (Arrieta H, 2018). The key here with the BRE Program approach is to use Provider skills to determine appropriate exercise and patient compliance techniques to assure maximum participation and effectiveness to the individual patients' abilities and preferences.

Additionally, less physical activity is associated with greater social isolation in the elderly, a known contributor to adverse health outcomes. "Greater social isolation in older men and women is related to reduced everyday objective physical activity and greater sedentary time. Differences in physical activity may contribute to the increased risk of ill-health and poor wellbeing associated with isolation" (Schrempft S, 2019).

Not only is social isolation related to less physical activity, but it also has adverse effects in and of itself. "There is consistent evidence linking social isolation and loneliness to worse cardiovascular and mental health outcomes" (Leigh-Hunt N, 2017). Not only does it worsen mental health and cardiovascular outcomes, but social isolation also negatively affects the subset of cognitive health (neuropsych). "Social isolation is associated with increased memory decline, rather than poor memory leading to increases in social isolation" (Read S, 2020). "Loneliness and isolation are associated with poorer cognitive function among older adults. Interventions to foster social connections may be particularly beneficial for individuals with low levels of education" (Shankar A, 2013). And "an extensive social network seems to protect against dementia" (Fratiglioni L, 2000).

Numerous studies have further demonstrated the positive effect of increased social connections and mental stimulation in the elderly. "Results suggest that stimulating activity, either mentally or socially oriented, may protect against dementia, indicating that both social interaction and intellectual stimulation may be relevant to preserving mental functioning in the elderly" (Wang XP, 2002). Furthermore, "there is epidemiological evidence that a lifestyle characterized by engagement in leisure activities of intellectual and social nature is associated with slower cognitive decline in healthy elderly and may reduce the risk of incident dementia. There is also evidence from functional imaging studies that subjects engaging in such leisure activities can clinically tolerate more AD pathology" (Scarmeas N, 2004).

Adequate nutrition is also an important factor in mental and cognitive health. Building on earlier analyses of epidemiological and observational studies (Ogawa S, 2014), a recent study showed that malnutrition was indeed associated with the psychiatric and behavioral symptoms of dementia (Kimura A, 2019).

Alzheimer's Disease pathology also shows a relationship to nutritional status. "Both AD biomarkers and cognitive performance were associated with nutritional status, associations with AD biomarkers remained after adjustment for cognition. Our data suggest that malnutrition is not only related to impaired cognition but also to AD pathology" (Doorduijn AS, 2019). It is important to note that much of the BRE program approach focuses on medication side effects, interactions, dosage, or sensitivity changes by the patient and the impact of poor nutrition and hydration. These concerns are addressed through continued interaction, including tracking and monitoring, and follow up with each patient as a consequence of the program and assigned CPT codes allowing for multiple approaches and integration of care strategies for optimal implementation for each patient.

Several studies have shown that meal delivery services, such as Meals on Wheels and other community-based charitable projects reduce hospitalization among frail and vulnerable adults (Cho J, 2018). One recent study showed a 387% return on investment in meal programs designed to reduce hospital readmission rates (Martin SL, 2018). These benefits add to good nutrition's mental and cognitive health benefits, including the social interaction that meal delivery creates. Coordination of these efforts through the BRE program can be time-consuming and often requires supportive access through other community resources to help with cost defrayment for those that are fiscally challenged and, in other cases, reliant upon volunteers and religious and or fraternal organization support.

As we all know, good mental health and normal cognitive function are the foundations of a healthy and productive life. Innumerable studies have shown that early identification of substance abuse, depression, suicidality, and cognitive decline, followed by appropriate medical treatment, follow-up, and community support, is essential to treating mental and cognitive health problems efficiently. The BRE Program seamlessly incorporates vital tools of identification,

tracking, monitoring, and treatment into existing doctor's offices, currently allowing seniors with Medicare broader access to efficient and effective treatment while preserving limited specialist time. Together, these effects reduce overall healthcare costs while producing better patient outcomes.

At present, the primary challenges to the program are:

1. Inequality of qualification and provider reimbursement for those with Medicaid. Typically, Medicaid requires prior authorizations for care that severely limit access for patients and, when approved, limit the ability to coordinate care, check and revise care as needed, track and monitor patient compliance with taking medications, being adequately hydrated with appropriate nutrition. All of this avoids unnecessary hospitalizations or institutionalizations for this population sector. Also, the reimbursement disparities between Medicare and Medicaid need to be addressed as that of Tricare, which affects our armed services personnel who have been completely ignored and provided adequate care.
2. Encouragement by lawmakers to use this "high level" approach across many affected patients with mild to moderate conditions as compared to a more intensive and rigorous evaluation and diagnosis for patients where more severe conditions are detected, and the psych and or neuropsych pathologies are the main focus of the care being offered by a specialist. By using regularly seen Providers who use the existing ICD/LCD/NCD guidelines along with related CPT codes, an instant increase in the capable workforce can be added along with using appropriately trained, leased staff that has specialized technology access to create consistency and efficiency of assessment evaluation, tracking, monitoring and disposition using both medical and lifestyle approaches.
3. Remove the threat of OIG and other watchdogs that use comparison statistics of codes to determine which providers are "abusing care" and which are not. Skilled providers that can help reduce the workforce problems are simply afraid because of this abusive tactic by law enforcement. It will be relatively easy to discern between use and abuse if the guidelines set in place according to ICD/NCD and LCD diagnoses codes are followed, then used to bill procedural codes for CPT coded services related to 96137 or 38, along with 96130-31 (psych) and 96132-33 (neuropsych) for evaluation and treatment. This is where the hallmark of good documentation and tracking is ever so crucial for good medicine practices.
4. Understand and grasp that improving this type of care availability will reduce long-term costs, improve quality of life, and allow more volunteers to assist. Many of these affected patients are capable of giving back once cared for appropriately. In addition, unnecessary hospitalizations for extended periods can be reduced along with the demand for more nursing homes and assisted care facilities. No patient wants to lose their living independence. Besides being costly, it is dehumanizing.

In the future, the BRE program could be expanded to offer services to more of the adult population, particularly those in high-risk groups, like those who are younger suffering from chronic pain and/or chronic health conditions. It is easy to start suffering from mental health-related concerns when good health is gone, and challenges to daily living become more and more burdensome.

The continued existence and success of the program depends on CMS policy that encourages mental health testing and treatment and allows for appropriate reimbursement of mental and cognitive health care services. We would ask for continued support and guidance in providing the most efficient and best possible mental and cognitive health care and are happy to testify and or work with any governmental or non-governmental group needing our feedback and recommendations.

Respectfully,

Dr. Ron Cohen
Founder & CEO
BRE Program Administrative Services

Citations

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