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In this episode of Health Care Law Today, Foley partner Emily Weber and associate Lauren Carboni talk with Dr. Casey Wolfington of Vail Health Eagle Valley Behavioral Health about behavioral health reform and a people-first approach to behavioral health care that is accessible, affordable and equitable.

We encourage you to listen to the podcast in its entirety.

Following is a transcript of this podcast.

Please note that the interview copy below is not verbatim. We do our best to provide you with a summary of what is covered during the show. Thank you for your consideration, and enjoy the show!
Podcast Transcript

Emily Weber is a health care lawyer with Foley & Lardner LLP and the office managing partner of the Denver office. Emily represents hospitals, health systems, academic medical centers, schools of medicine, physician groups, and health care technology companies. Emily focuses her practice on complex health care regulations and transactions, governance, fraud and abuse, health innovation, HIPAA and data privacy matters.

Lauren Carboni is health care attorney with Foley & Lardner LLP and is a member of the Foley Health Care & Life Sciences Sector, the Health Care Practice Group, and the Foley Cannabis Industry Team. Lauren’s practice focuses on health care and cannabis regulatory and litigation matters. As both a health care regulatory attorney and litigator, she brings a unique perspective to counseling clients on business strategy, fraud and abuse protection, regulatory compliance matters, and investigation defense.

Dr. Casey Wolfington is a licensed psychologist and the Senior Director of Community Behavioral Health for Eagle Valley Behavioral Health, an affiliate of Vail Health. Dr. Wolfington has focused her career on the development of behavioral health workforce strategy with a specific focus on rural communities. Dr. Wolfington founded, developed, and supervised several student-training programs, including the creation and accreditation of Colorado’s only rural APA-accredited Predoctoral Internship Consortium. As of 2022, over 50 students have completed their clinical training under her supervision. Dr. Wolfington also has a passion for health care law, health care policy, and ensuring law and policy align with clinical practice and prioritize patient care.

Emily Weber

Thanks Judy. And I'd like to introduce myself. I'm Emily Weber. I'm a partner at Foley & Lardner in the Denver office. My focus is on health care regulatory and transactional work. And I'd like to introduce our two other guests today. We have Dr. Casey Wolfington, who is a senior director of Community Behavioral Health at Vail Health Eagle Valley Behavioral Health, as well as Lauren Carboni, who is an associate here at Foley & Lardner in Denver, who also focuses on healthcare regulatory and transactional work. So Lauren, maybe you can take it away with our first topic and question.
Lauren Carboni

Thanks, Emily, I'm looking forward to our discussion today with Casey. So we wanted to talk a bit today about behavioral health, which is Casey's expertise. So let's just start off right from there. So Colorado, like many other states is at a crossroads right now regarding behavioral health reform. Casey, what legal constraints do you see in the ability to provide care?

Casey Wolfington

Absolutely. It's such a good question and you're right. I think the fact is that Colorado was at a crossroads and has been for a while, but like so many things, behavioral health reform, and the need for it was really highlighted as a result of this pandemic. I think some of the most important concepts, when we think about behavioral health reform, we think about parity. We think about HIPAA. We think about telehealth and I'm sure across our conversation today, we'll talk about all of these, but I think something that I have a lot of conversations with is this concept of parity and what it actually means and whether or not it truly applies to behavioral health, especially in a rural community. And so this idea of parity is seen as this new concept, but parity has been around since the 1960s, but the concept of parity enforcement is something that's gotten a lot more attention lately. And really, when we look at parity, especially in our rural communities, it's not just access to behavioral health care and coverage for behavioral health care, but truly having local access to the same type of providers and the same type of care that you would for a behavioral health diagnosis, as you would a physical health diagnosis. And I'm sure that's something that you guys hear a lot about in your work as well.

Emily Weber

And what you see when you talk about parity and sort of in relation to, I will say "traditional, non-behavioral health" health care, what do you see as the biggest differences between someone getting access to health care let's say if they have a heart disease versus they have a behavioral health issue? And it could be everything from social stigmas to other more kind of practical issues about access to care.

Casey Wolfington

Yeah, a hundred percent. I would say that the vast majority of the conversations that
I hear in the public arena have to do with access to care coverage of services, having perhaps a limited number of behavioral health sessions, where you wouldn't have a limited number of sessions to see a family practice doc or PCP or something along those lines. So I think that gives the vast majority of the media attention, but I think parity really, truly starts even before there. If we look at medical providers, the vast majority of medical providers are paneled with insurance, but only 20% of behavioral health providers are paneled with commercial insurance. And so, if we're thinking about just the provider networks, provider adequacy and the number of individuals that we have access to, we already have such a limited number of behavioral health providers that are participating in that marketplace that it's hard to have true parity.

Emily Weber

And I would ask another question, actually, in relation to Lauren's first question, which was in a perfect world, what would you, if there were no legal constraints or in other words, what are the legal constraints that you say someone doesn't have access to health care or behavioral health healthcare. There's certain things that, for example, I'm always telling you that you can and can't do, right?

Casey Wolfington

Yes.

Emily Weber

What would be, let's say, your top three or top two things that you wish you would never hear from me again?

Casey Wolfington

Oh, Emily, I love hearing everything that you tell me, but I think one of the biggest pieces is the balance between true provision of client-centered care and client privacy. I think you and myself and Lauren, we have a lot of conversations about HIPAA and the impact of privacy laws and ensuring that we're protecting individuals' information, but the interesting component about HIPAA maybe how it was created and developed and it was designed to protect individuals and prevent discrimination and discrimination against behavioral health diagnoses. But I think what providers often have seen or see, is that often it gets in the way of care. And that I think that we know this is one of the reasons primary care is so effective as a behavioral health service delivery mechanism because the greater picture we have of someone's total health, the greater the health outcomes are going to be, whether that's physical health or psychological health. And so for me, I think if we could really understand why HIPAA is in place and what it's designed to do versus not designed to do because actually, Emily, I think a lot of our conversations that you and I have are about exceptions to HIPAA, but I don't think a lot of providers are aware.

Emily Weber

Or that they really... It's not that they don't care, it's that they're trying to do the best thing for the patient, which doesn't necessarily reconcile with the law. And, I
will say there have been a number of examples and Casey, maybe you can talk about this, of course, without giving any PHI.

**Casey Wolfington**

Without breaking HIPAA.

**Emily Weber**

Without breaking HIPAA, but the idea of having your task forces. And I think that's a good example of what necessarily is the best thing for the patient or to prevent harm to person or public doesn't necessarily jive with HIPAA.

**Lauren Carboni**

What's encouraging is there are proposed rules to the HIPAA privacy rule. They had an extended comment period. I think it ended in May of 2021. And so there is a final rule on the horizon that's going to amend the privacy rule and it's been stated that one of the big purposes is to remove the administrative burdens on covered entities. And some of the amendments do tend to promote greater care coordination and case management. So it'll be interesting to see what the final rules actually say. However, I think even once the final rules come out, I think there's going to be a significant period of time to implement any such changes, like the policies and practices that need to go in place, retraining people on the new HIPAA, redoing all of the paperwork that you already have in place complying with HIPAA.

So I think upfront, it may create additional administrative burdens, but perhaps in the end game here, these changes to HIPAA will better allow for the holistic patient care. And, Emily, sometimes what's in the patient's best interest doesn't necessarily comply with HIPAA, which I don't think that was originally what the rule is supposed to be for, right?

**Casey Wolfington**

Yes, absolutely. And I think you hit another nail on the head is this fact of the care coordination, the navigation, all of these support pieces. And if we're thinking about a greater umbrella of behavioral health reform, most behavioral health providers, like we talked about, are not paneled with insurance. They're doing private pay fee for service-type sessions. And so it's very difficult to have a reimbursement mechanism for some of those supportive services that, again, align with best patient practice, best care coordination, having conversation with your parents at the school, how engaged your parents are with the school. If you're working with a family or talking with a child's teachers, these are crucial conversations to have all of which right are involved HIPAA protections, but also this change and prioritizing care coordination rather than just service appointments and procedures.

**Emily Weber**

That's right. And I actually think more frequently than I would've thought maybe five, ten years ago, people use HIPAA as an excuse to not disclose information when HIPAA does not apply to them at all. So for example, there's certainly other laws that apply, but if you want to get access, let's say from a school about a child's
mental health, they may say, "I can't because of HIPAA." While they're not a covered entity, so that it's both a hindrance, but also a crutch.

**Casey Wolfington**

Yes, and I think it's lack of training. I think, Emily, your conversations that you, myself, and Lauren have are so incredibly informative, but I think the vast majority of behavioral health providers don't have extensive HIPAA training outside of employment-based training that they may have when they're entering a job. At Vail Health, we go through HIPAA training, but if you're not in a covered entity, you may not understand those aspects of it.

**Lauren Carboni**

I wonder if that should fall in part on the state or the federal, I guess, the federal government in the case of HIPAA, but to require providers participate in X amount of HIPAA training or something. I don't think they have any requirement now, do they?

**Emily Weber**

A licensure requirement? That's a great idea.

**Lauren Carboni**

A licensure requirement or something, yes.

**Casey Wolfington**

No, I don't think they have any, but I feel like not only would that be a fabulous requirement, but I think the behavioral health providers would welcome it because it's only through conversations with you guys that I have actually started to view HIPAA as not such a hindrance and a barrier in that there are allowances to be able to engage in this care coordination. So I think a lot of it could be supported through training.

**Emily Weber**

Especially through DORA when you do your licensure accreditation. It's a great idea, Lauren.

**Lauren Carboni**

All right. I'll call DORA.

**Emily Weber**

That's right. Any day now.

**Lauren Carboni**

Yes, right? But I look forward to when the new rule comes out. I don't think they've released anything on when it's actually going to come out, but they are trying to get to the heart of that, Casey, the care coordination and management. I believe they're
calling it, they're going to allow for PHI to be shared amongst covered entities and other entities that provide “ancillary and health related services,” I think is how they're defining that category. But I think it will encompass what you're saying, the ability to share with your children's schools information and other organizations in the community that provide services to the patient that may not necessarily follow within treatment. Let's shift to our next question. So what can and should be done at the state and federal levels to better allow behavioral healthcare providers to share patient health information?

**Casey Wolfington**

Well, I think you guys just said it. I think better training on understanding, not just the intention of the laws, but I think historically if you talk about how HIPAA was created and why it exists, I think it gives providers a greater understanding rather than this really black and white view of what HIPAA is and what it is not. And I think every behavioral health provider, probably if they were asked to describe HIPAA, it has to do with protections, but then huge fees if you break it. So I think that there's this big piece of never wanting to violate HIPAA, which I think is so incredibly important, but that they don't really understand what HIPAA is. And it isn't because I think you're exactly right, Emily, that people often say this is HIPAA protected when it's absolutely not.

**Emily Weber**

Right, and I might actually, just real quick while we're talking about the law, go off of HIPAA for a second, because, of course, HIPAA is first and foremost in the front of our mind when we talk about this, but there's a lot of other health care laws. And I think Casey and Lauren, we were always talking about compliance with the Stark Law and compliance with the Anti-kickback Statute. And I think Casey, maybe you can talk a little bit about the CMHC that Eagle Valley Behavioral Health was just so fortunate to get that designation from OBH here in Colorado and about how you can do both big picture or whatever details you want to get. In a perfect world, if you were to set up that CMHC, that Community Mental Health Center, and to have all of these relationships with other organizations and providers out there, what would that look like in terms of providing the best care—keeping people out of the emergency room? What does it look like when we talk about this all the time? Having small physician groups or small FQHCs that don't have the resources that other entities do? What does that look like from more of a structural perspective in terms moving money around?

**Casey Wolfington**

Yes, absolutely, it's a huge point. I would say actually in an ideal world, I'm going to go into what your question is, but I'm going to say it in a different way. First, Eagle Valley Behavioral Health became a community mental health center for a number of reasons. One of them to be, to recognize the great work that has already been happening in our community, that our community partners are doing. Essentially a community mental health center is a designation that's awarded through the office of behavioral health that talks about delivering services in a community safety net services. And it's the entire continuum of care. It goes from prevention and education all the way to emergency and crisis response. So it is somebody who is
designated to ensure that these services are being delivered for a community in the best way possible.

And with that typically comes some level of funding, but it also comes with certain designations that you had talked about Lauren, is this idea that you can provide care coordination service, outreach services, navigation services, all these things that we know are tied to health outcomes. We recognize that prevention services aren't just important to our youth, that we have to continue doing prevention services to our entire population so that we can address substance use, that we can address mental health and depression and anxiety. And that's come up now more importantly than ever with the pandemic, we're seeing more and more employers want to engage in these preventative and educational tools. But again, it goes back to how traditional reimbursement is structured and typically it's fee for service. So without a designation like a community mental health center, your ability to get funding for some of these very, very important health outcome program areas is limited.

So I would say if I really had an ideal view of the world, it would be to have reimbursement for some of these important behavioral health services be incredibly community-directed rather than having to receive a designation in order to get them. But then I think your greater question is that all of this is tied together. Again, I'm going to go back to this COVID analogy, but we now see how health can have an impact, and we can start to see signs of behavioral health deteriorating. And then we can see an increase in call volume to our crisis hotlines. And we can see a greater amount of patients showing up in our primary care organization, our outpatient clinics. And so everything is tied together. And so the ability to share information for individuals that might be showing sign of concern very, very early on, which usually that's in our prevention education forum. So if we're doing presentations to schools or workforce, and maybe we have an indication that somebody might be struggling more than normal, it's great to be able to share that information and engage with that individual early, rather than waiting until they are in crisis and they show up in our emergency room.

On a national level, this is a time that I think everyone agrees that the emergency room is the probably worst place to treat a behavioral health condition. It's where we're just managing a crisis and it's the most costly to the individual. It's the most costly to the community and in terms of risk; it's the highest risk for that patient. And so we're trying to make sure that we can catch these individuals early and often. And when we have that umbrella of care that you're talking about Emily, that's where we can catch individuals. But it's also what you spoke of, is there's lots of typically, I guess there's lots of silos that keep that information separate and within each organization, rather than seen as a continuum of care

Emily Weber

And who should pay for that? Because I'm sitting here thinking if someone's having a bad day or if they're having a series of bad days and they need to get help. I mean, one thing I guess, one way to think about it is your insurance should pay for it. Of course, those of us on a high deductible health plan, we're ultimately paying for it. But I also think, especially Casey, as you know, I have strong ties to the Vail Valley. I would say, you probably have some data, the number of individuals there that are either uninsured or those that are sort of seasonal workers that are underinsured
and those individuals probably have a hard time when the cost of living is so high and the wages aren't keeping in touch with that. But then, you also have someone saying, "Well, you can see someone for a hundred dollars for 30 minutes." I mean, that's a hard burden.

Casey Wolfington

Well, 100%. It's interesting because we do in our community, we have one of the highest rates of uninsured, one of the highest rates of underinsured, and we have a behavioral health scholarship program it's called Olivia's Fund where we can provide behavioral health services for those that qualify with a financial need. But one of the interesting pieces of that, the vast majority of the individuals who apply for that have insurance. So what we're recognizing is what you touched upon before is even if you are insured, that high deductible or maybe the co-insurance that goes along with it, or the co-pay becomes so unobtainable, that really your access is still incredibly limited. So yeah, I think that's exactly right.

Lauren Carboni

And it's interesting to me because I feel like there's still potentially a stigma around behavioral health or we're still coming to the realization that preventative care and access to behavioral health is the same priority as your physical health. If there's a hundred dollar fee with a therapist for an hour versus going to your doctor for some physical ailment, I feel like, I don't know, people still may be inclined to spend the money for the physical ailment and maybe not realizing my mental health is being affected and could be causing the physical ailments I'm experiencing. But I don't know. It's just interesting to me that I just think the two areas, physical health and behavioral health are still siloed and maybe we are now starting to see them come together. And especially because of the pandemic. And, with kiddos in particular, all of us have been impacted by COVID, but I feel like kids in particular, are having to cope with things that they never had before and that ability to have access to behavioral health care should be there and ability to pay should not be an issue.

Emily Weber

No. And, I think that the sort of COVID and kids issue really is a big behavioral health one. I mean, as her parent, I have the authority to say this about my daughter, but she is a good girl. She seven years old and she's really, I think she's had some challenges because masks are a good thing, but you can't see someone's face and sort of it starts at a young age of learning those social and emotional cues and what that means for a young person and trying to sort of find their way through this world to understand what that means. And I think COVID is a huge issue. And, I think going to your point, Lauren and Casey, about sort of the stigma of behavioral health, I think part of it, of course, is this is nothing new, but if you had a cancer diagnosis, you wouldn't just say just deal with it, buckle down. Buckle down and grit your teeth and bear it. And I think as attorneys we are we're probably the worst at this. I think the rate of depression amongst attorneys is probably one of the highest in any profession. I mean, we're doing great here, but-

Lauren Carboni
Emily Weber

Yeah, but I do think that it is that issue of saying it's not everyone has hard days, but I'm having a series or a pattern of really hard days. And when do I say, "I need to get some help." And I think EAP programs can be the number one way that can be benefits at least to start benefits for employers to provide to their employees about saying, you need to talk with someone, even if it's just one time to blow off some steam, but you can't just grin and bear it.

Casey Wolfington

Well and I think what you guys are both describing is a perspective shift. It's this idea that we've always viewed behavioral health as something is going wrong. And you go to therapy to manage that symptom rather than viewing behavioral health as a preventative tool, of if we have stronger coping skills and better emotional regulation skills, that we're going to be better really at everything in our entire life, from parenting to our performance at work. And the EAP model, Emily, I love that you brought that up because I agree. I think that really embraces it, is here's X amount of sessions that you can use, whether something is wrong or if you just want to talk about being better at something at work or whatever's going on with you, it takes away that stigma, it takes away the need to feel like you have a diagnosis to have to utilize it.

Emily Weber

That's something needs to get to like a crisis level. Dr. Wolfington you are a clinical psychologist. I feel like Lauren and I are having a therapy session right now with you.

Casey Wolfington

Oh, I love it.

Lauren Carboni

Is it something that EAPs are starting to provide or is it still kind of the outlier?

Emily Weber

I think so. No, I think they are.

Casey Wolfington

Yes. And I think it's how the view is because again, I love the history of some of this, but EAPs were originally created in the 1960s and '70s, because it was commonplace for individuals and certain professions to have work meetings that engaged in alcohol. And so they recognized that they were somewhat contributing to a problem of their employees. And so that's how it started. But so many companies have embraced it now, of just saying, "We want you to be your best self and this is going to help you engage in better performance at work, better relationships with your
colleagues." And so I think instead of having it viewed as this is something that's a deterrent that it feels like it's just something that someone has to do or they're doing because something's wrong at work. I think about how it's being marketed and it's this is about performance. And if we look at professional athletes, the vast majority of professional athletes have sports psychologist, they have a performance coach, they have someone that's helping them get through.

Emily Weber

Honestly, it sounds ridiculous, but that is such a great point. Professional athletes have a sports psychologist. Other professionals should have an attorney psychologist, I'm serious. I think that it's actually really good food for thought. Hmm... interesting.

Casey Wolfington

Absolutely, and at Vail Health we launched this Mountain Strong EAP, and a lot of it is focused on health care specific support and it was launched right before COVID. And I would say that I feel like it's an incredible saving grace of having individuals that understand the stress of being a health care worker, understand the different phases of this pandemic and what that has meant for varying health care workers. And I think that has impacted our ability to, especially being in the mountains where we've been hotspots at various times lately with Omicron, I think it's really changed the mindset of staff. And I think it's also given leadership the ability to feel like they have a tool to help support individuals.

Emily Weber

That's perfect. And yeah, I think it's a really important tool and I hope that more organizations adopt that. And I will say we have about five minutes left, which is also important because we are having an automatic required restart on our computer in about eight minutes. So this will be good timing. So, Lauren, I know you have another one or two really important questions we'd love to hear Casey's feedback on.

Lauren Carboni

Yes, I think since we already sort of discussed behavioral health and minors, but Casey, I'd love to briefly discuss issues with treating minors that are unique to behavioral health and sort of what created these issues.

Casey Wolfington

Yeah. I think oftentimes that the issues created are a result of really well intended individuals, isn't that always the case? Originally we had laws in effect or statutes in effect, you guys will tell me the right term, but that allowed the provision of services for 15 plus, which is interesting because when we think about adults who can consent to services or consent to different things, you think about the age of 18. So even just having a different age for behavioral health providers, it can be confusing. And then in 2019, that age of consent was reduced to 12, which is fabulous because the intention behind that is to ensure students that are in school
can access behavioral health services without having the impact of a parent, especially if the parent is contributing to behavioral health hardship. So the intention is really great, but again, the way laws are written, it can be very confusing.

And some of the wording of the laws leave a lot to interpretation as a behavioral health provider may allow someone 12 plus to consent for services. And, I will say, as a behavioral health provider, as Emily mentioned, I'm a psychologist, sometimes we like our rules to be pretty black and white. So does that mean all 12-year-olds? Does that some 12-year-olds? What does that mean for bills? What does that mean for insurances? And parents can still access files up until someone's 18. And so what privacy can you really guarantee someone who is 12 plus? And do you want the parents not to be involved? Because as you guys both know, parents have a pretty big role in a 12 to 18-year-old's life. And so should they be involved with care?

Emily Weber

If they're lucky they do. Depending on the day maybe.

Casey Wolfington

That's true, that's true. And so, I think the biggest thing, Lauren, going back to your question, is there's a lot of different laws. There's a lot of different change and so much is left to interpretation that it makes it really confusing.

Lauren Carboni

So how do behavioral health providers navigate the complexity of the laws, that interpretation? Is it just kind of a judgment call? Do organizations tend to have, here's our best practice or a policy of how you address treatment of minors or is the attorney always on call, I guess?

Casey Wolfington

Well, for me, you guys are always on call, which I feel so lucky for. But I would say that every provider adopts their own policy. And that again is what makes it very high hard is if I'm a patient, I may call one provider and get a response and then I may feel like services are not available to me even though that's that one organization's policy or that one provider's policy. And so I think that's the piece that's hard too, is when someone is seeking care, I think that they're at their most vulnerable. And so if we have a 12-year-old and they call one provider, they make theirselves vulnerable and try to seek out care and they say, "Nope, I need your parents' permission. That's my policy regardless of the law." It might shut down their ability to even make another call for care. Even though there might be someone else out there that really engages in that best practice of providing services for 12 plus.

Emily Weber

And I know we're all parents on this call, so, on the flip side, I think it requires parents to have a lot of trust in their community providers if this were to move forward.
Casey Wolfington

Well, and it actually goes back to what you talked about real quick, Emily, too, is if you can think about behavioral health as prevention and that maybe engaging a kiddo in services before something's wrong, maybe then a relationship established and it makes it easier to access care.

Emily Weber

Right. And on that note, I will say, I think we are just about out of time, but Casey, we can't thank you enough for all of the insight and kind of thought leadership you've put into this and certainly for what you've put together in the Eagle River Valley for the community there, it's really one of a kind. And on that note, thank you, Lauren, and I will say back to you, Judy.

END OF TRANSCRIPT

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