INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE

AN ACTIONABLE FRAMEWORK FOR ADVANCING INTEGRATED CARE

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A Collaboration For Studies In Primary Care

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Summary

Important strides have been made to help more Americans access health care services, but by nearly every measure the United States continues to deliver highly fragmented, inefficient, and expensive care. As attention on improving the quality of care provided to individuals and families increases, ensuring that patients receive well-integrated care[1] is a critical piece.

To create a Culture of Health, multiple new pathways for integrating health and health care sectors are needed. Patients, families, and communities have identified an especially high need for integrating behavioral health and primary care. Where such care has emerged, it appears to improve health and health care and contain costs.

The Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Denver, with support from the Robert Wood Johnson Foundation, developed a comprehensive report with recommendations that provide a catalyst for moving integration of primary care and behavioral health forward.[2]

1. Peek CJ. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. Agency for Healthcare Research and Quality, Rockville, MD. 2013.

2. This issue brief summarizes the findings of the full report, "Creating a Culture of Whole Health: Multi-Method Recommendations for Integrating Behavioral Health and Primary Care."

The Vision of Integrated Primary Care

There is a traditional and conceptual divide in medicine between the health of the mind and the body. Even though there exists irrefutable scientific evidence that the two relate and influence each other, the U.S. health care system persists in considering them distinct disciplines. Physicians and behavioral health clinicians train separately, have surprisingly little capacity to work across specialties, and are paid differently for their work. Nevertheless, the need for integration is great. Nearly half of adults (46%) and 28 percent of children can be expected to experience a mental health illness or substance abuse disorder during their lives,[3,4] making the consequences of poor integration potentially devastating.

Although one in five primary care visits relates to mental health, 66 percent of primary care providers report being unable to connect their patients with appropriate follow-up resources because of a shortage of mental health clinicians and health insurance barriers.[5] Roughly two in three adults with behavior disorders (67%) go untreated by mental health clinicians; 50 percent of those with depression aren't properly diagnosed by their regular doctor.[6,7]

The economic toll is staggering. Per capita U.S. health care costs are more than $9,500 annually, according to the government's latest figures, with four of the top five drivers of total workplace health costs being mental health problems, or physical symptoms exacerbated by mental health conditions: depression, anxiety, obesity, back and neck pain, and arthritis.[8]

3. Kessler RC, Wang PS. The descriptive epidemiology of commonly occurring mental disorders in the United States. Annu Rev Public Health. 2008 Apr 21;29:115-29.

4. Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). Journal of the American Academy of Child & Adolescent Psychiatry. 2010 Oct 31;49(10):980-9.

5. Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. Health Affairs. 2009 May 1;28(3):w490-501.

6. Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, Wang P, Wells KB, Zaslavsky AM. Prevalence and treatment of mental disorders, 1990 to 2003. N Engl J Med. 2005 Jun 16;352(24):2515-23.

7. Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. Lancet. 2009 Aug 28;374(9690):609-19.

8. Loeppke R, Taitel M, Haufle V, Parry T, Kessler RC, Jinnett K. Health and productivity as a business strategy: a multiemployer study. Journal of Occupational and Environmental Medicine. 2009 Apr 1; 51(4), 411

Although the health care system differentiates physical and behavioral health care, patients don't. They seek care where they can in a single setting—with a particular provider they trust, in a clinic that is convenient. Because of the artificial division between mind and body, they are often forced to delay, forgo, or receive inappropriate care until something spirals into a crisis. There should be no "wrong door" preventing patients from accessing appropriate care. The personal and economic consequences call out for concrete action toward better integration of behavioral health into the health system—beginning with primary care, where patients are likely to seek help first.

While integrated care at the community level doesn't guarantee a Culture of Health, it has great promise to advance one under proper conditions. To make that a reality, the health care system can help clinicians integrate practices by providing training resources and technical assistance, creating new tools to help them better track patients, using big data to understand communities, and finding payment models which reward new ways of staying up-to-date on the latest clinical standards. Under these circumstances, practices can be better enabled to handle acute care and would be able to shift focus toward prevention and intervention.

Clinicians could get out from behind clinic walls to engage with communities and work collaboratively with other clinicians, community leaders, and government officials to proactively address problems and manage resources more effectively. In places where integrated care has emerged, the benefits are impressive. More than 75 trials of integrated approaches to care show significant clinical benefits in

depression and anxiety.[9] In one five-year, federally funded study, researchers observed that medical use decreased 15.7 percent among those who received integrated behavioral health treatments, while it increased 12.3 percent among those who did not. Beyond the topline clinical result, it found that costs related to depression for those with diabetes, for example, were $896 lower over 24 months and $3,300 lower over 48 months.[10]

In order to better understand how clinicians deliver and patients receive care, the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Denver undertook a broad inquiry into the barriers that have stymied integration of behavioral health and primary care, while creating an actionable set of recommendations to overcome them. In the process, more than 70 experts from across the field were consulted. The resulting paper summarizes discussions and forms the basis for actionable, interrelated recommendations.

Every stakeholder—including clinicians and their professional societies; policymakers and academics; businesses and philanthropies—has a role to play. Overcoming barriers requires stakeholders to work within a coordinated framework toward redesign and integration. While the process will be complicated, the transition could help create a Culture of Health that strives to keep people healthy with comprehensive, whole-person care.

9. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012 Oct;10(10).

10. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012 Oct;10(10).

Recommendations for Policymakers and Payers

Invest in a national technical assistance center focused on health policy to provide direct consultation and support to states on work related to behavioral health and primary care integration. For example, the technical assistance center could work to revise and harmonize federal, state, and local policy and regulatory barriers and identify how to overcome these to enable patient-centered, integrated behavioral health care (e.g., 42 CFR part 2, which governs the confidentiality of some patient medical records).

Establish an alternative payment methodology framework which supports, through various models, the integration of behavioral and primary care services, considers the community in which the practice operates, and incorporates variation in the local health care marketplace (e.g., payer type, health care workforce, socio-demographics of patient panel). These various payment approaches should be in support of the team and not the individual provider therefore enhancing the likelihood of integration's success.

Tap and use existing real-time data to form interdisciplinary links and areas for action between health systems and other public policy areas (e.g., criminal justice, violence prevention, education, environment, and racial equity). These data could lead to targeted programs and policy changes in support of more robust behavioral health and primary care services.

Include interventions for prevention and early intervention (e.g., screening, treatment, management, and follow-up) as an essential health insurance benefit with appropriate payment models in support of the integrated team.

Recommendations for Providers, Their Professional Societies, and Academics

Design and scale competencies for behavioral health providers working in primary care and partner with local colleges and professional societies to adapt these competencies to curriculum that could be endorsed by relevant national licensing and board certification authorities. Establishing a standard for competencies can help better enable integrated efforts' success.

Engage communities to better understand their behavioral health needs and use as a platform for intentional, evidence-based public education. Create community assessments for integration and leverage data, from the community, on ways to advance the communities' needs for behavioral health (e.g. create policy recommendations, infographics, and patient stories).

Implement rapid cycle learning for integration which can be applied and disseminated immediately. Build infrastructure and multi-modal strategies such as specific tracks at conferences and improve accessibility and presentation of community level data with use of visuals: maps, graphs, videos, and appropriate language for ease of use and consistent messages among diverse stakeholders.

Develop and disseminate in-depth case studies and best practices to policymakers and payers on operationalizing behavioral health integration in publicly and commercially financed primary care and outline population health management strategies including non-visit based services (e.g., asynchronous communication, telehealth).

Develop assessment tools to measure the competency of the integration workforce. These tools could be applied at a community, practice, and provider level to assure consistency across care delivery and measure progress in development and change.

Develop mechanisms for reviewing and updating evidence to establish minimum clinical standards for behavioral health and primary care integration. These can be informed by existing resources like the Agency for Healthcare Research and Quality's Lexicon, Peek's 5 R's [i.e. 1) relevant, 2) rapid and recursive, 3) redefines rigor, 4) reports on resources required, 5) replicable][11], and Sackett's definition for evidence-based practice.

11. Peek CJ, Glasgow RE, Stange KC, Klesges LM, Purcell EP, Kessler RS. The 5 R's: an emerging bold standard for conducting relevant research in a changing world. The Annals of Family Medicine. 2014 Sep 1;12(5):447-55.

Recommendations for Philanthropy and Business

Fund experimental payment models and sites or support existing innovative communities (e.g. communities where payment innovation for behavioral health is occurring) to assess specific elements of payment models that support integration. Scale payment models for integration to other states and communities with broad-based philanthropic support and business investment. Develop technical assistance for multiple payment entities with an eye on policy.

Develop shared models and enhance health IT functionality and data standards for behavioral health which can be adopted across systems.

Create a payment hub to study various models and organize itself as a resource and proactive matchmaker for stakeholders across the country interested in replicating successful payment approaches.

Explore the use of technology for prevention and early intervention and create a repository of promising technologies that support prevention (e.g. parent portals and text-based counseling).

Create resources, templates, and technical assistance strategies to improve access to data for patients and other providers through education on how the Health Insurance Portability and Accountability Act (HIPAA) can serve as a facilitator for more robust integration, rather than a predominate barrier.

Opening the Door to Comprehensive Healthcare

AN ACTIONABLE FRAMEWORK FOR ADVANCING INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE

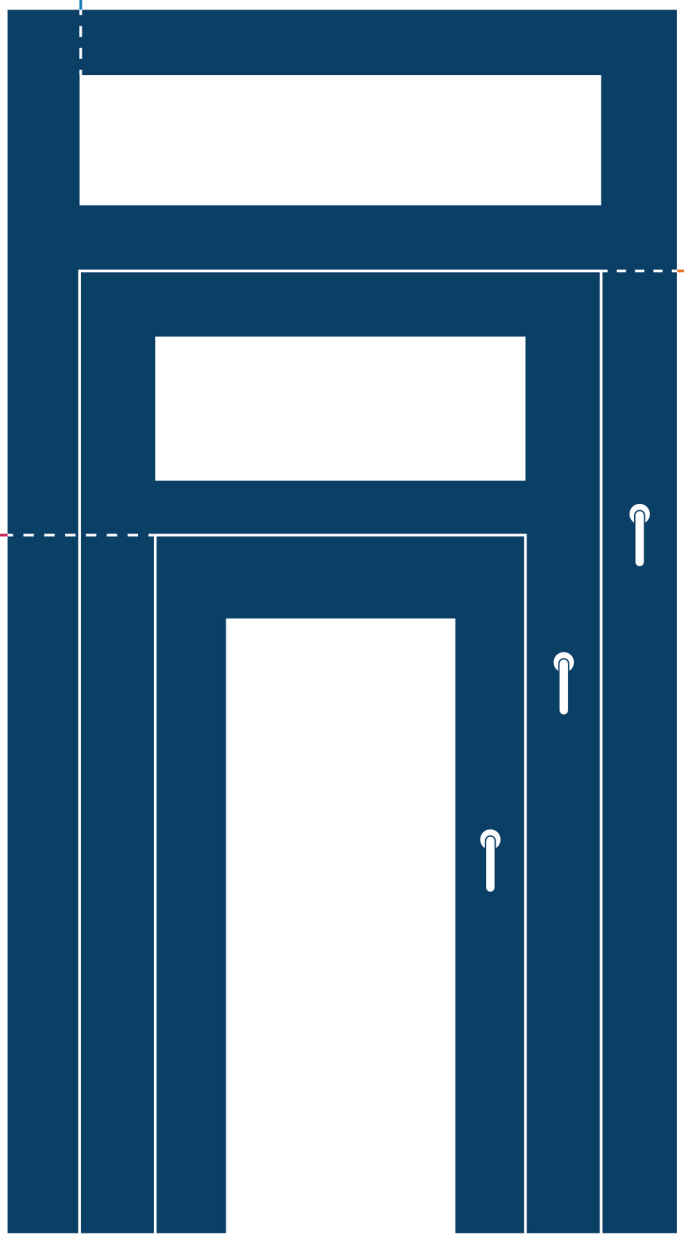
Policymakers & Payers

Invest in a national technical assistance center focused on health policy

Establish an alternative payment methodology framework

Tap and use existing real-time data

Include intervention for prevention



Clinicians, their Professional Societies, & Academics

Design and scale competencies for behavioral health providers working in primary care

Engage communities

Implement rapid cycle learning for integration

Develop and disseminate in-depth case studies and best practices to policymakers and payers

Develop assessment tools

Develop mechanisms for reviewing and updating evidence

Philanthropy & Businesses

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Create a payment hub to study various models

Explore the use of technology for prevention and early intervention

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