INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

Integrating Primary Care and Behavioral Health Care

(October 31, 2008)

Executive Summary:

The success of the Triple Aim — simultaneously improving the patient care experience and health of entire communities, while reducing per capita cost — is in part determined by the ability to integrate all aspects of health and health care. There is preliminary evidence that successful integration of primary care and behavioral health care leads to better care of both the physical and behavioral health needs of patients. This type of integration is taking place in pockets throughout the United States health care system; however, there is a lack of data demonstrating results. Most health care organizations that have been successful with integration are in the process of conducting data analysis to determine results. Furthermore, it is believed that integrating primary and behavioral health care saves money for the overall system. There are four primary drivers of successful integration of behavioral health into primary care:

- Education and training (providers and patients);
- Shared physical space and patient record;
- Identification and treatment of patients based on need (without limitations); and
- Shared funding or other successful funding mechanisms.

I. Research and Development Team:

- Leader: Lindsay Martin, IHI
- Colleague (Helper): Peter Brown, Institute for Behavioral Healthcare Improvement (IBHI)

II. Intent:

The intent of this 90-day project is to support the pursuit of the Triple Aim — simultaneously improving the patient care experience and health of entire communities, while reducing per capita cost — by identifying the most promising approaches to addressing together the physical and behavioral aspects of care. There is some evidence and much belief that in order to improve the patient care experience, achieve improved population health, and lower per capita costs, the health care system must address both the physical and the behavioral aspects of health and morbidities experienced by the population. This 90-day project explored promising approaches and the connections between the disciplines and practices, with a goal of defining mechanisms for attaining better use of all these capabilities together to achieve the Triple Aim. The specific focus was the integration of behavioral health into primary care. Although integration of primary care into behavioral health is also necessary, particularly for individuals with significant behavioral health needs who do not see primary care personnel as their first line of caregivers, this project did not address that aspect.

III. Background:

There have been many reports documenting the connection between behavioral morbidities and other morbidities. Behavioral health problems are known to slow or halt prevention and treatment of chronic conditions such as diabetes, heart failure, asthma, and obesity. In addition there is a

fairly general recognition of the significant impact of behavioral morbidities on these and other major public health issues, and on unhealthy behaviors such as smoking and use of drugs and alcohol. Further, there is a growing recognition of the impact of physical morbidities on behavioral health problems. The clinical directors of the National Association of State Mental Health Program Directors reported that people with serious behavioral health conditions die 25 to 31 years sooner than the general population. In most cases, these premature deaths result from chronic diseases that could have been better managed in the primary care system than having their primary care needs addressed in the context of behavioral health. In fact, 60 percent of premature deaths of persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infectious diseases.

There is also a belief that many individuals treated in the primary care system do not receive care for their behavioral health needs. In the United States, depression affects more than 19 million individuals each year. Furthermore, in 2003, 54 percent of people with mental health issues were treated in general medicine only, rather than in combination with specialty medical services for their behavioral health needs. Achieving a system of health support and health care will require the competencies of all disciplines directed at assuring public health.

Although there is a growing understanding of the interconnections between physical and behavioral health, these fields are very often not connected, or not sufficiently connected to achieve the Triple Aim. Integration of the physical and behavioral health care fields with the goal of improving population health is both promising and filled with challenges. There is a historic separation between the fields, driven by professional, systemic, and fiscal issues, which cause fragmentation, a lack of understanding and mistrust. There are also varying levels of integration of primary care and behavioral health that result in different levels of success in their outcomes:

- Minimal collaboration;
- Basic collaboration at a distance;
- Basic on-site collaboration;
- Partial integration; and
- Full integration.

One proposed model for integration by Mauer and colleagues (see Figure 1) is the Four Quadrant Model which segments the level of care a patient receives based on the level of severity of physical health (PH) and behavioral health (BH) needs.

Figure 1: Four Quadrant Model

	Physical Health Risk/Status	
Behavioral Health Risk/Status	**Quadrant II** *BH High* *PH Low* *Served in specialty BH system that coordinates with PCP to ensure access*	**Quadrant IV** *BH High* *PH High* *Served in both the specialty BH and primary care/medical specialty systems*
	Quadrant I *BH Low* *PH Low* *Served in primary care with on-site BH staff*	**Quadrant III** *BH Low* *PH High* *Served in primary care/medical specialty system with on-site BH staff*

IV. Description of Work to Date:
Key literature was reviewed and interviews with experts were conducted including:

- Barbara Mauer, MSW CMC, Managing Consultant, Strategic and Organizational Planning
- Joe Parks, MD, Division of Comprehensive Psychiatric Services, Department of Missouri Mental Health
- Phyllis Kaye, MPS, American Public Health Association
- Robin Dea, MD, The Permanente Medical Group

The majority of the 90-day project team's efforts and learning came from investigating and interviewing sites engaged in integration, including:

- White River Junction VA Medical Center
- CareOregon
- Primary Care Coalition
- Washtenaw Community Health Organization
- Intermountain Healthcare
- North Colorado Health Alliance
- Maine Health
- Southcentral Foundation
- Kaiser Permanente of Northern California

V. Results of the 90-Day Scan:

Rules for Getting Started

Integration of primary care and behavioral health is taking place in pockets throughout the US health care system, although clearly defined systemic models for successful integration are lacking. The number of people receiving mental health and/or substance abuse treatment in community health centers increased from 210,000 in 1998 to 800,000 in 2003. In addition there are several health care organizations creating differing types of integration programs. The most successful fully integrated organizations interviewed by the 90-day project team had several components in place prior to or during their initial launch of integration efforts.

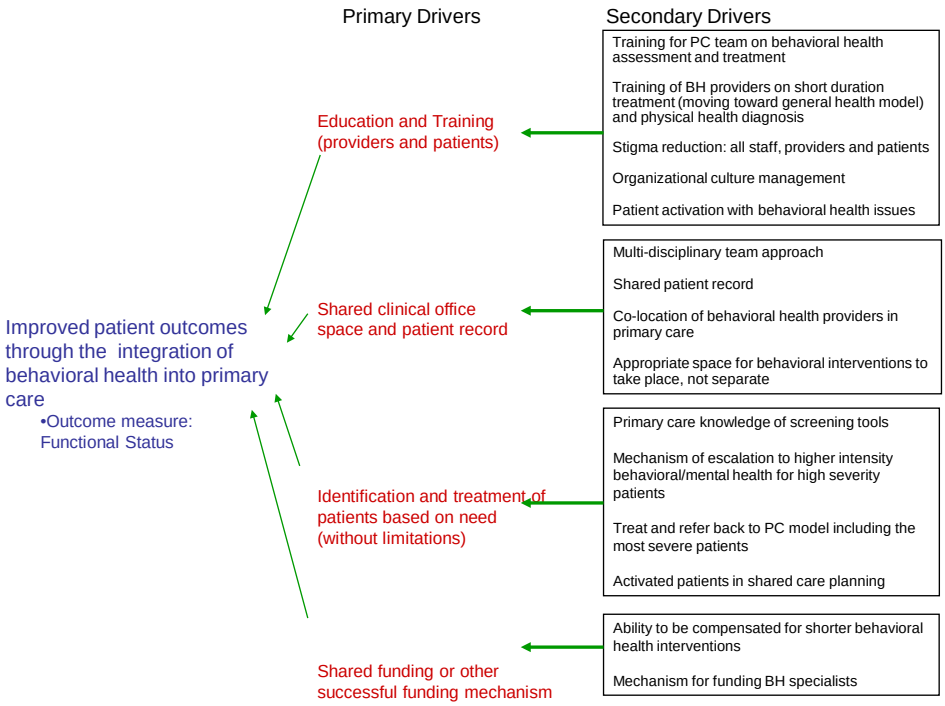
The "rules" for getting started are as follows:

- Identify champions in both primary care and behavioral care. Given the differences between these two fields it is important that each field has a champion to move the integration effort forward and to bring along the laggards.
- Take an inventory of community services that are available to serve both primary care and behavioral health needs along with social needs and meet with these organizations to identify opportunities for collaboration. Referral for services such as housing, food, and other needs is often necessary. Forming a close relationship with community service organizations will both reduce the burden on the health care practice and enhance the network and coordination of services for patients. This is particularly crucial for practices in rural areas where resources may be scarce and separated by a significant distance.
- Identify and recruit behavioral health providers who are able to perform short duration treatment (moving toward a general health model). Integrating behavioral health into primary care requires a divergence from typical behavioral health interventions. Interventions will need to be shorter, occur in different locations (such as in exam rooms), and focus on direct solutions rather than on problem solving over time. There are only two known programs in the United States that currently train providers in this type of intervention, the University of Massachusetts and the University of Tennessee. It is important to look for behavioral health providers who have experience in a clinical setting and are comfortable practicing or learning to practice in this environment.
- Create a plan for conflict resolution. Uniting two very different fields (primary care and behavioral health) will inevitably create challenges. By acknowledging this up front and having an agreed plan for addressing differences, the integration team will be able to move more quickly to resolution.
- Plan for ongoing team meetings, trainings, and development. Integrating behavioral health and primary care is an ongoing process. As the program grows, more staff will become involved in the efforts and additional challenges will arise that need to be addressed. It is important to have an ongoing training and meeting structure in place.

Components of Successful Integration

Figure 2 is a driver diagram that depicts key components for improving patient outcomes by successfully integrating behavioral health into primary care.

Figure 2: Driver Diagram for Improving Patient Outcomes by Integrating Behavioral Health into Primary Care



The four primary drivers are described in more detail below:

- **Education and training (providers and patients):** Education and training of all members of the practice is necessary. Primary care providers need to learn how to conduct behavioral health assessments and begin subsequent treatment; behavioral health providers need to be trained both in short duration treatment and in physical health diagnosis, especially for common chronic conditions. All staff and patients need to be trained in reducing the stigma that still surrounds behavioral health. All staff need to be comfortable with this aspect of morbidity and treatment and patients need to learn to discuss these behavioral health concerns with their providers, many of which they may never have discussed in the past. Furthermore, patients and providers need to be familiar with patient activation around behavioral health challenges, empowering the patient to take control of both physical and behavioral health needs. It is also important for all members of the practice to be trained in organizational culture management because two very different cultures are being brought together.

- **Shared clinical office space and patient record:** A multidisciplinary team that shares the same clinical office space and is fully integrated is essential for the success of this work. It is also important that all providers are able to access and use a shared patient record to ensure that information is available to the entire care team as needed. While an electronic medical record is helpful in this regard, it is not essential as long as there is another mechanism for sharing information. In addition to primary care and behavioral health providers being located in the same clinical space, there needs to be appropriate physical

space for behavioral health interventions to take place, either in a dedicated office within the same area or within the traditional exam room, or a combination of the two.

- **Identification and treatment of patients based on need (without limitations):** Identifying behavioral health needs and assessing the severity of the need is paramount. Some sites use screening tools for depression, substance abuse, anxiety, etc. Other sites rely on providers learning to ask the right questions that will unveil these behavioral health problems. National organizations have been actively encouraging the use of tools, known as Screening Brief Intervention and Referral to Treatment (S-BIRT) and the PHQ-9, as mechanisms for early detection and intervention in behavioral health areas. In addition, other proactive screening can be conducted to look at patient groups that have higher rates of behavioral health needs, including somatic problems such as headaches and stomach complaints. The behavioral health provider and/or primary care provider will establish a treatment for the patient and follow through with it. For patients that present with severe behavioral health needs, access to a higher level of care will be necessary and a mechanism needs to be in place, for example, having a psychiatrist on staff or having access to an appropriate care provider by pager all day, everyday. The model of "treat in specialty care and return back to primary care" should be the goal, even for patients with the most complex mental health needs. For all patients it is important that there is a mechanism for follow-up. As discovered during this 90-day project, most successful practices used case managers to both follow up with patients and bring patients back into care if they haven't been seen on a routine schedule.

- **Shared funding or other successful funding mechanism:** Funding is one of the most significant barriers to integrating behavioral health care into primary care. Primary care and behavioral health are typically reimbursed through separate mechanisms. It is important to find a way to pay for the behavioral health provider given that short-duration behavioral health interventions that occur in primary care are not a typical billing code.

<u>Changes for Patients with Successful Integration</u>

The goal of successful integration of primary care and behavioral health is to better serve the needs of patients and achieve better health outcomes. The following example from Southcentral Foundation in Alaska demonstrates how a typical patient would have been treated before and after the integration of primary care and behavioral health.

- *Patient*: A low-income mother suffering from depression and diabetes.

- *Typical care prior to integration*: The patient is seen by a primary care provider mostly for her acute needs, or when there is a significant problem. Most likely her medications would change frequently to try to control her diabetes. Her diabetes is not treated as a chronic condition because it would be necessary to focus on the acute flare-up. Her depression is not addressed.

- *Typical care after integration*: The patient is followed closely by a case manager because she is low-income. In addition, a nurse case manager reviews her lipids regularly and calls the patient if they need to be addressed or if she has missed

appointments. The patient is screened once a year for her depression because she is a diabetic. If she screens positive for depression, she is seen immediately by a behavioral health consultant. There is ongoing monitoring of both her diabetes and her depression by her care team. Because she is diabetic and at higher risk for behavioral health issues, regardless of whether there is a current behavioral health diagnosis, the patient is seen once a year by a behavioral health consultant to assess behavioral health needs and to discuss any needed behavioral modifications.

Barriers to Successful Integration

Integration of primary care and behavioral health is possible, however, there are significant barriers that need to be removed or addressed. These barriers include:

- Financial risk: Who assumes the risk, the primary care provider or the behavioral health provider, for not being able to bill adequately to cover the costs of care provided?
- Availability of demonstrated health improvements: There is a lack of quantitative health outcomes data that demonstrates the success of integration. Most of the organizations interviewed during this 90-day project indicated that lack of outcomes data was a result of not collecting the data to enable the necessary analysis. Traditionally, data collection at the start of integration consists of descriptive data around access and patient demographics. Most integration programs are now moving toward collecting both health outcomes and behavioral health data. As evident in the driver diagram, we propose using a measure of functional health that will help assess both the physical health and mental/behavioral health of patients (although additional research is necessary to demonstrate that this is the best metric to use).
- Stigma associated with behavioral health: As stated earlier there is still a significant stigma associated with behavioral health needs. It is important that providers, patients, and office staff become comfortable with serving patients' behavioral health needs.
- Confusion around definitions: The terms behavioral health, mental health, and substance abuse are often used interchangeably or share common elements. The most successful programs view the integration of primary care and behavioral health as including components of all three (behavioral health, substance abuse, and mental health) since it is difficult for providers to separate needs based on the lack of definitions and the overlap in conditions and causes.
- Acclimation of primary care providers and behavioral health providers to a new model of care: Change is difficult in any circumstance and the addition of different models of care further complicates the change.
- Shortage of the "right" behavioral health providers: As mentioned earlier there are only two educational programs available at present that solely train doctorate level psychologists. Most integration programs rely on master's level practitioners to serve as front-line behavioral health providers.
- Integration in geographically isolated locations: Rural settings face greater challenges because providers and community resources are often less available. In addition, sharing behavioral health providers between separate sites may be necessary, which could disrupt the continuity of care or result in patients not being seen by a behavioral health provider on the day of their primary care visit, if necessary.

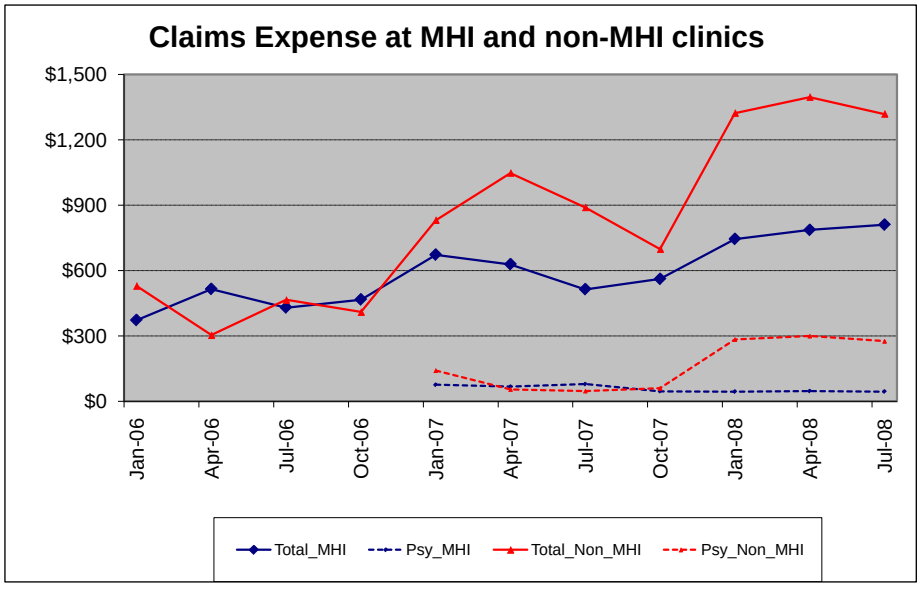
- The traditional split in health care between mind and body: This split has persisted in the United States for generations. It will take a lot of effort from providers and patients to bring together care for both mind and body.

Business Case Implications

While many organizations claim that there are cost savings associated with the integration of primary care and behavioral health, few have collected the data to demonstrate these savings. However, given the perceived success of the integration program, organizations are now moving towards measuring this information. Two organizations interviewed during this 90-day project have already started this analysis: Intermountain Healthcare (Salt Lake City, Utah) and Southcentral Foundation (Anchorage, Alaska).

Intermountain Healthcare currently has 68 primary care sites that are at various stages of integrating primary care and behavioral health. Of these 68 clinics, 12 are considered routinized (i.e., integrated for three years and integration is the norm). Preliminary analysis comparing claims at clinics with mental health integration (MHI) and claims at clinics without mental health integration demonstrate fewer claims with respect to both total primary care and psychiatry in clinics with mental health integration (see Figure 3).

Figure 3: Intermountain Healthcare Claim Comparison



Southcentral Foundation began integrating primary care and behavioral health four-and–a-half years ago. In addition to integrating behavioral health, Southcentral Foundation has a multidisciplinary team approach that focuses on the patient as the costumer. At present, they are demonstrating the value of integration by showing a reduction in utilization of other high-cost services. (At Southcentral Foundation there is incentive to reduce the number of visits due to their payment scheme). Their successes include a 19 percent decrease in ER visits for patients who have

been seen by a behavioral health consultant. There has also been a 40 percent reduction in pediatric visits, and an 8 percent reduction in family medicine visits. In addition, there have been decreases in appointments to rheumatology and orthopedics, in part because of their focus on pain management in the integrated clinics. Southcentral has seen an increase in visits to complimentary and traditional healing services and to behavioral health services outside of the integrated clinic. The next step in Southcentral Foundation's analysis is to assess changes in the overall cost per capita.

VII. Conclusions and Recommendations:

Successful integration of behavioral health and primary care is occurring in pockets across the United States. Whereas several years ago most of these organizations felt isolated and lacked a peer group with whom to review their progress, there is now a growing network of organizations who believe in and practice integration. In addition, there are conferences and meetings structured around integration. While there is scarcity of data at present that demonstrate the improved physical heath outcomes of patients who are in integrated systems, there is mounting evidence of the need and success of integration. The progress the organizations interviewed during this 90-day project make should continued to be followed by IHI and IBHI as most were in the process of analyzing both the health outcomes and the financial outcomes of their programs. Despite the success in these early adoptor settings, integration of care is neither simple nor uniformly accepted. Any integrative effort requires careful planning and management to be successful and achieve high-quality results.

Within IHI this content has already been shared with the Triple Aim initiative teams. In addition, it will be handed off to the team leading the strategic partnership with the Indian Health Service, and the IMPACT outpatient team.

VI. Open Questions:

- What is the best way to address the financial challenges of integration? Does the payment mechanism need to be altered to compensate appropriately for integration?
- Is functional health status the best measurement of overall improvement for primary care and behavioral health integration?
- How should physical health care be addressed for patients with the most complex behavioral health/mental health problems whose care predominately resides with mental health providers?

If additional exploration is to be conducted by either IHI or IBHI, the following options could be considered:

- An initiative to further investigate the problems of billing and reimbursement for needed behavioral health care and to develop specific protocols for addressing problems or recommendations for structural changes in billing and reimbursement.
- A methodology for assisting primary care systems and providers to comfortably accept and integrate behavioral health systems and services into the primary care setting and network. This product should be carefully constructed to help providers of all types deal with the many aspects of care integration of care.