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Integrating Behavioral and Physical Health Care Delivery: An Important Step Towards Whole Person Care

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The Importance of Integration

70% of people receive behavioral health care in primary care settings[1]

More than two-thirds of primary care visits are related to psychosocial issues[2]

Only 36% of individuals with mental health disorders receive treatment and only 12% get minimally adequate treatment[3]

[1]Blount FA, Miller BF. Addressing the workforce crisis in integrated primary care. Journal of Clinical Psychology in Medical Settings. 2009;16(1):113-9.
[2]Robinson P, Reiter, J. . Behavioral Consultation and Primary Care: A Guide to Integrating Services. New York: Springer; 2007.
[3]Russell L. Mental Health Care Services in Primary Care: Tackling the Issues in the Context of Health Care Reform. Center for American Progress; 2010.

Evolving Models of Integration: Common Concepts

- Medical/Health Care Home
- Health Care Team
- Stepped Care
- Four Quadrant Clinical Integration

Collins et al, Evolving Models of Behavioral Health Integration in Primary Care, Milbank Memorial Fund, 2010

The Safety Net Post ACA: The Push to Integrate Care

- The changing landscape of health care delivery
  - Triple aims
    - Better care
    - Better health
    - Lower costs
- Community Health Centers (CHCs) as the cornerstone of the safety net
- A paradigm shift in perception of CHCs
  - From "providers of last resort" to "providers of choice"

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Health Policy Brief

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One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five California Community Health Centers

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SUMMARY: More than 70 percent of behavioral health conditions are first diagnosed in the primary care setting. Yet physical and behavioral health care are typically provided separately, compelling many vulnerable patients to navigate the complexities of two separate systems of care. This policy brief examines five community health centers (CHCs) in California that have taken preliminary steps toward creating "one-stop shopping" for both physical and behavioral health care. The steps taken to increase integration by the CHCs include employing behavioral health providers, using a single electronic health record that includes both physical and behavioral health data, transforming the physical space, and developing mechanisms for effective transition of patients between providers. The findings emphasize the importance of changes to Medi-Cal reimbursement policies to promote same-day visits, as well as the importance of cultural changes to integrate behavioral health. They also highlight the need for comprehensive tools to assess and promote integration and to identify solutions for the most challenging activities required to achieve full integration.

Segregation and lack of coordination between primary care providers (PCPs) and behavioral health providers (BHPs) are significant problems. More than 70 percent of behavioral health conditions are diagnosed and treated with medications in the primary care setting, yet PCPs frequently do not have the training to identify behavioral health problems or the resources to provide all of the care that symptomatic patients need.[1,2,3,4] Complex patients with both behavioral and physical conditions often have high rates of emergency department visits and hospitalizations, and they often receive inadequate care.[5]

Behavioral health includes mental health care, substance abuse treatment, and behavioral modification. Participating CHCs were asked about integration of all such services.

The focus on the Triple Aim of better care, better health, and lower costs mandated by the Affordable Care Act has intensified efforts to improve the health of complex patients. Increasingly, physical and behavioral health integration is being targeted by policymakers as a promising approach to improving the health of publicly insured and uninsured patients, and at the same time reducing their health care costs.

Data Sources

- Highly structured and semi-structured interviews
- Site visits (two sites)
- California Office of Statewide Planning and Development (OSHPD) 2013 community clinic data
- NCQA and Joint Commission PCMH recognition/certification lists

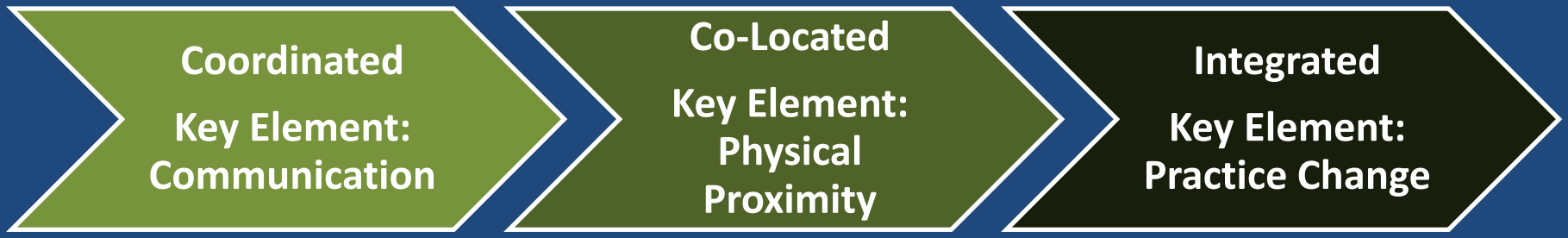
CHC Selection Criteria

Participation in the Low Income Health Program (LIHP)

Licensed and operating CHCs providing primary care to the general population

Recognized as PCMH by NCQA

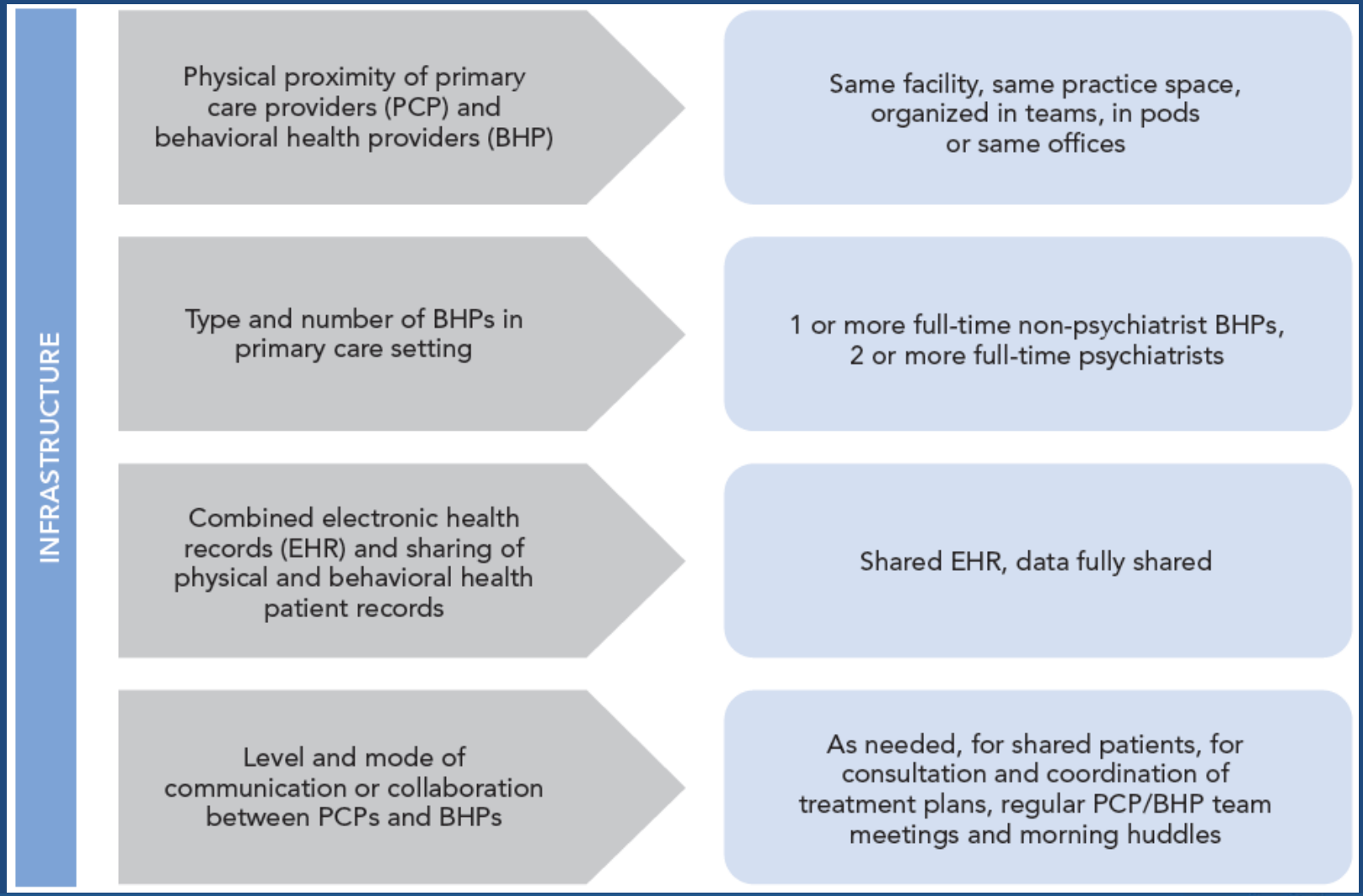
SAHMSA/HRSA Framework for Integration



Infrastructure: Levels

SAHMSA-HRSA Model		Coordinated		Co-Located		Integrated	
		1: Minimal collaboration	2: Basic collaboration at a distance	3: Basic collaboration on-site	4: Close collaboration on-site with some system integration	5: Close collaboration approaching an integrated practice	6: Full collaboration in a transformed/ merged/ integrated practice
INFRASTRUCTURE	Physical proximity of primary care (PCP) and behavioral health providers (BHPs)	Separate facilities	Separate facilities	Same facility	Same practice space and facility	Organized in teams, in same practice space and facility	Organized in pods or same offices and teams, same practice space and facility
	Type and number of BHPs in primary care setting	None	None	Fewer than 1 full-time or temporary non-MD BHP (psychologist/ LCSW/intern)	1 or more full-time non-MD BHPs and/or volunteer psychiatrist	1 full- or part-time psychiatrist, 1 or more full-time non-MD BHPs	2 or more full-time psychiatrists, 1 or more full-time non-MD BHPs
	Combined electronic health records (EHRs) and sharing of physical and behavioral health patient records	Separate EHRs, data not shared	Data not shared	Data shared on case-by-case basis, separate EHRs	BHP inputs of selected data in medical EHR, separate EHRs	Shared EHR, selected behavioral health data visible to PCP	Data fully shared in shared EHR
	Level and mode of communication or collaboration between PCPs and BHPs	Sporadically by email/phone for specific patients	Sporadically for shared patients	Occasionally for shared patients	As needed for shared patients, for consultation and coordination of treatment plans	BHPs occasionally attend team meetings, as needed for shared patients, for consultation and coordination of treatment plans	In regular PCP/ BHP team meetings and in morning huddles, as needed for shared patients, for consultation and coordination of treatment plans

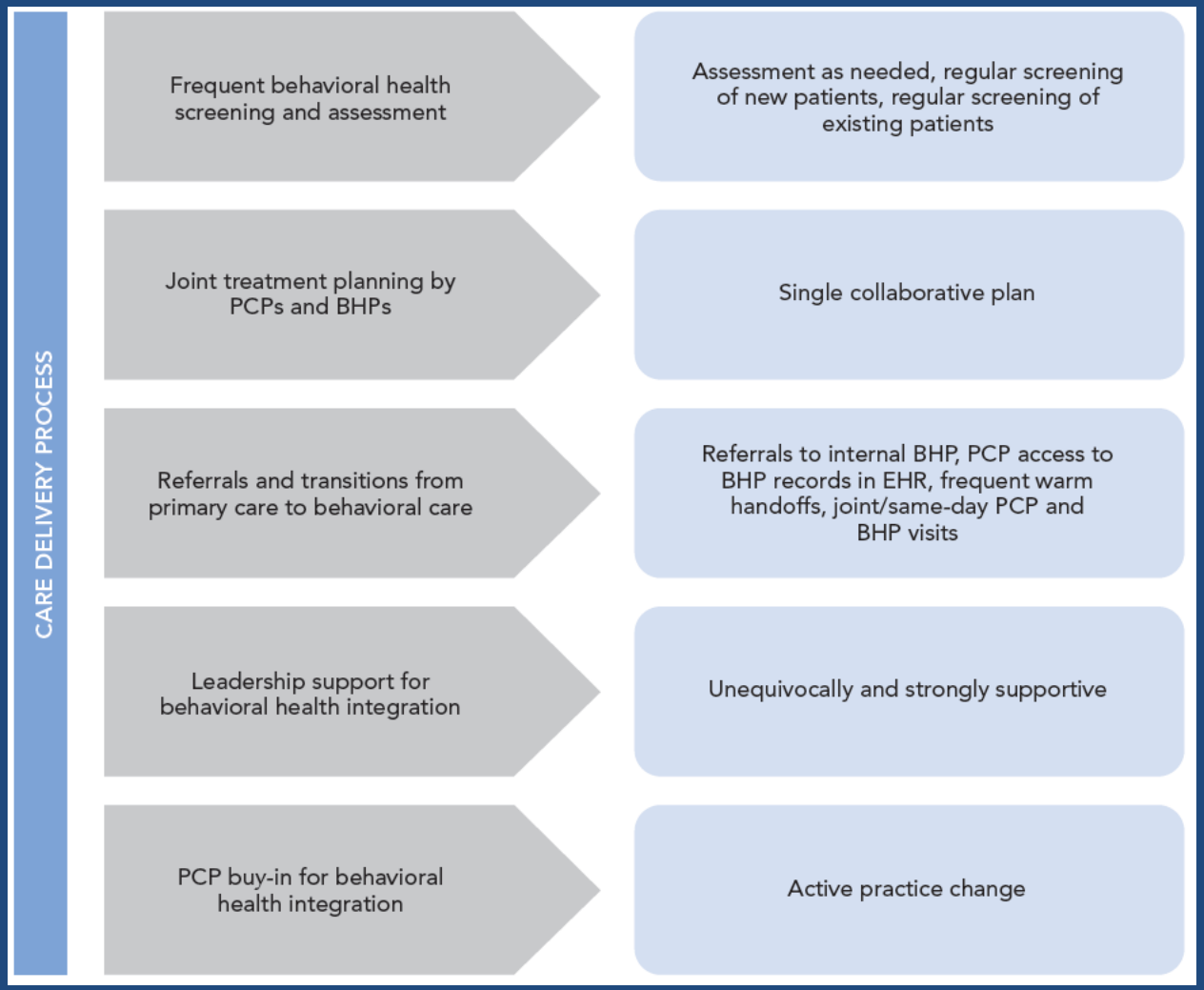
Infrastructure: Best Practices



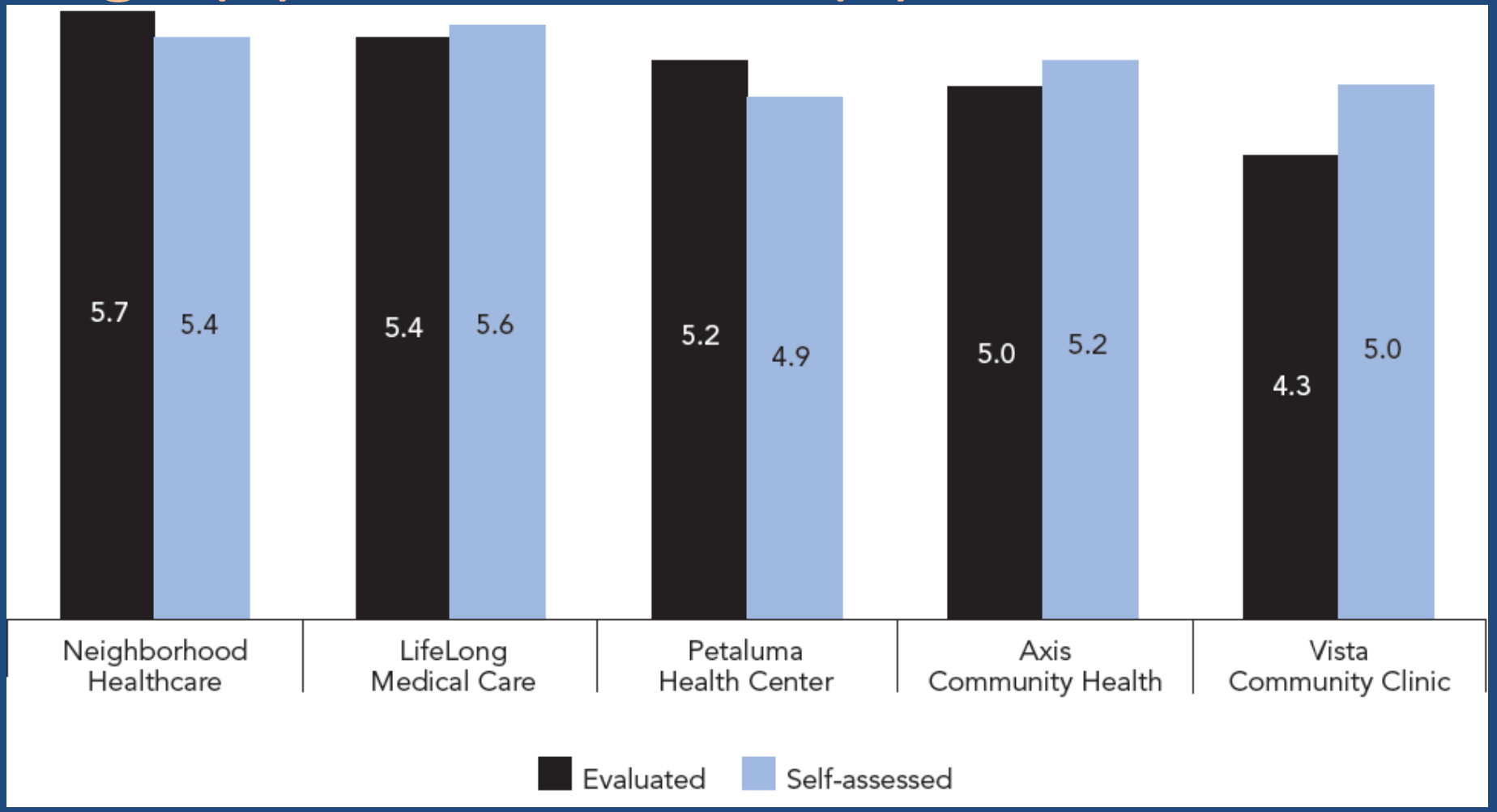
Care Delivery Process: Levels

SAHMSA-HRSA Model		Coordinated		Co-Located		Integrated	
		1: Minimal collaboration	2: Basic collaboration at a distance	3: Basic collaboration on-site	4: Close collaboration on-site with some system integration	5: Close collaboration approaching an integrated practice	6: Full collaboration in a transformed/ merged/ integrated practice
CARE DELIVERY PROCESS	Behavioral health screening and assessment frequency	Assessment as needed	Assessment as needed	Occasional screening of new patients, assessment as needed	Regular screening of new patients, assessment as needed	As-needed screening of existing patients, regular screening of new patients, assessment as needed	Regular screening of existing patients, regular screening of new patients, assessment as needed
	Joint treatment planning by PCPs and BHPs	Separate plans	Limited sharing of plans, separate plans	Usual sharing of plans, separate plans	Some collaborative planning, separate plans	Frequent collaborative planning, separate plans	Single collaborative plan
	Referrals and transitions from primary care to behavioral care	Referrals to external BHP, no follow-up or feedback	Occasional follow-up and feedback, referrals to external BHP	Referrals to internal BHP, occasional follow-up and feedback	Follow-up and feedback through EHR messaging, occasional warm handoffs, referrals to internal BHP	PCP access to BHP records in EHR, frequent warm handoffs, referrals to internal BHP	Joint/same-day PCP and BHP visits, referrals to internal BHP, PCP access to BHP records in EHR, frequent warm handoffs
	Leadership support for behavioral health integration	None	For information sharing	For special projects, primarily	For mutual problem solving	Supportive but varies with funding availability	Unequivocally and strongly supportive
	PCP buy-in for behavioral health integration	Little	Some	For referrals	Inconsistent buy-in	Has not led to practice change	Active practice change

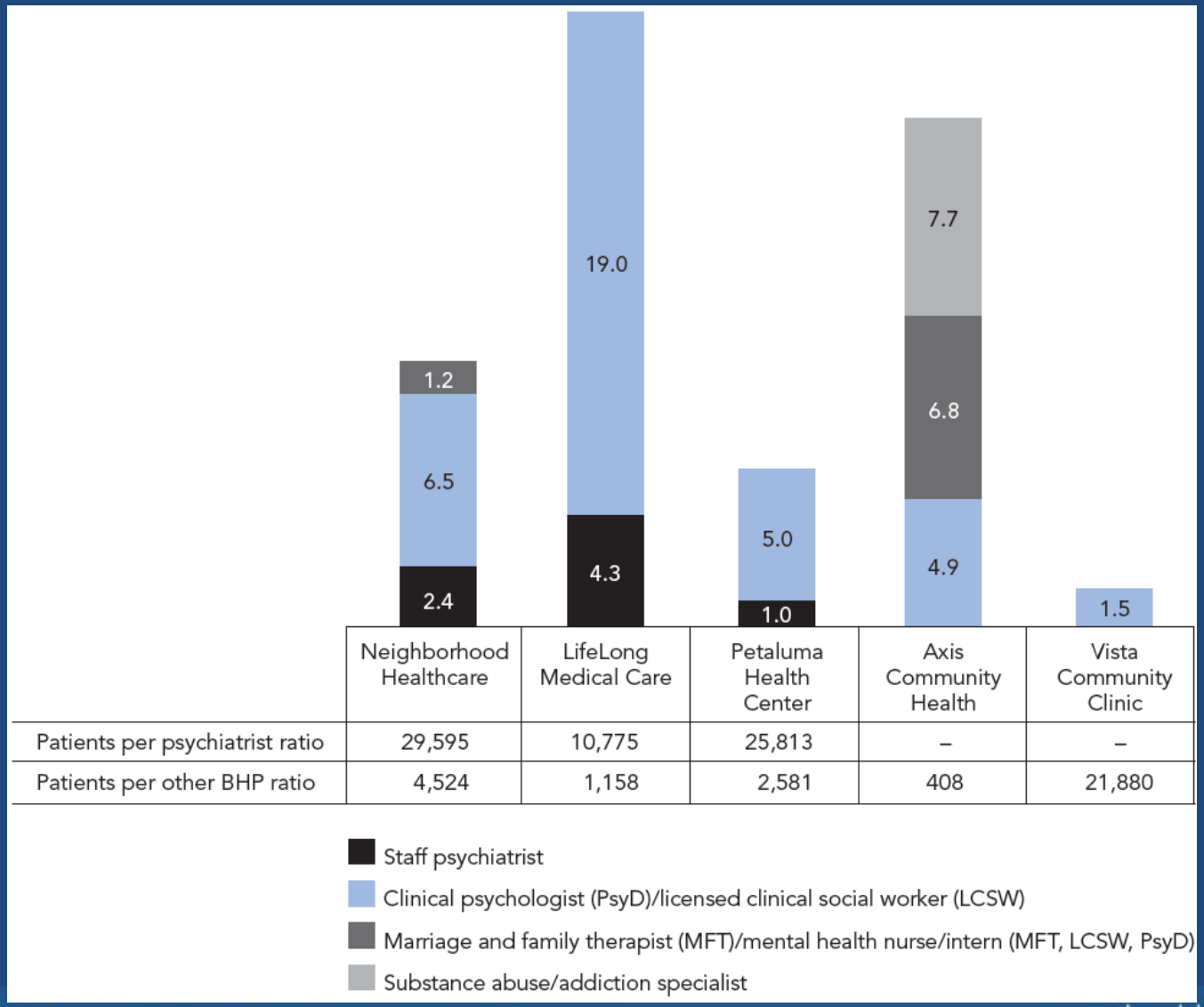
Care Delivery Process: Best Practices



Integration in CHCs: High (6) to Low Scores (1)

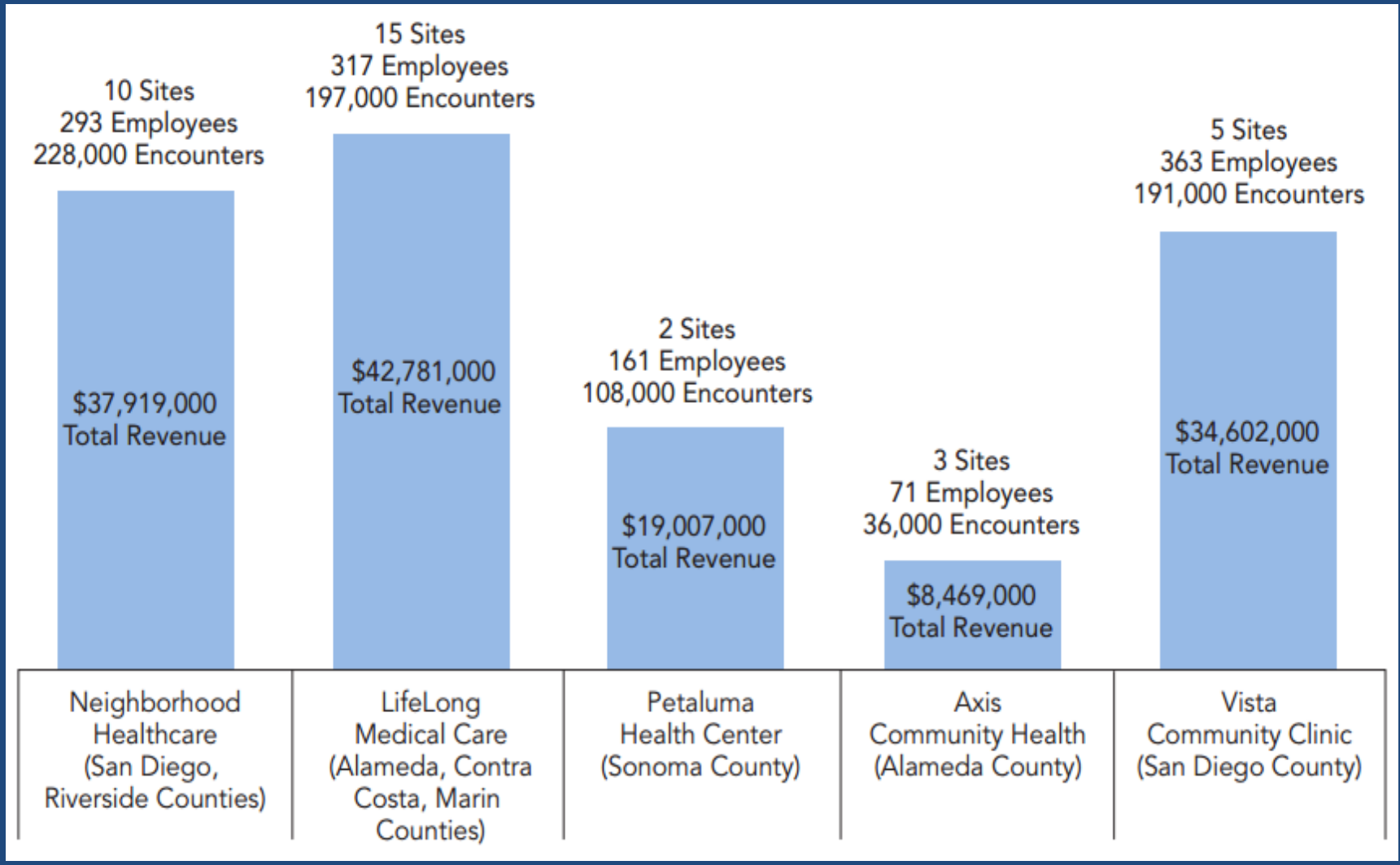


Behavioral Health Workforce & Capacity



	Neighborhood Healthcare	LifeLong Medical Care	Petaluma Health Center	Axis Community Health	Vista Community Clinic
Patients per psychiatrist ratio	29,595	10,775	25,813	–	–
Patients per other BHP ratio	4,524	1,158	2,581	408	21,880

Characteristics of Participating CHCs, 2013



Challenges

- Difficulty recruiting highly skilled BHPs
- Lack of physical space to reorganize clinics into integrated provider teams
- Same-day visit reimbursement limitations
- High demand for behavioral health services

Moving Forward

- Notable progress, more to be done
  - CHCs at forefront of integration
- Insure adequacy of BH workforce
- Include BH in QI and daily clinic operations
- Include BH providers in decision making & leadership
- Address reimbursement challenges