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Integrating Behavioral Health into Primary Care: Lessons Learned from the Comprehensive Primary Care Initiative

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Table of Contents

- Introduction 3
- What is BHI? 3
- The Comprehensive Primary Care Initiative 4
- CPC Change Tactics for Integrating Behavioral Health 5
- Behavioral Health in CPC 5
- CPC Case Studies 5
- Lessons Learned in BHI 7
- Next Steps for BHI 8
- Behavioral Health Tools and Resources 9
- The Future of Behavioral Health in Primary Care 9
- References 10

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Introduction

The interplay of primary care and behavioral health has long been recognized in practice and medical literature. However, despite philosophical agreement on the importance of an approach to care that integrates physical, mental, social and emotional aspects of a patient, limited resources exist within many practices to operationalize this comprehensive approach to primary care. A majority of patients with behavioral health concerns often present in emergency departments and primary care clinics; however, providers often lack the time, training and/or staff resources to recognize and treat behavioral health conditions.

New payment models that provide incentives for improving health outcomes and reducing health care spending may provide the means for providers to fully embrace team-based care and better integrate behavioral health services into the care model. For example, in managing patients with diabetes under a value-based care model, if the patient is depressed (approximately 40 percent of patients with diabetes suffer from some form of depression), that patient will not be able to get their blood sugar under control unless they address their depression. Recognizing the need to address the co-occurrence of depression in patients with diabetes, behavioral health intervention is key (Terry 2016).

In one such alternative payment model, the Comprehensive Primary Care (CPC) initiative, providers were incentivized to integrate behavioral health into their practices. In this paper, we will present key lessons learned from CPC practices that successfully achieved behavioral health integration (BHI).

What is BHI?

Many previous discussions of BHI within primary care have languished in definitional battles about what truly constitutes BHI. The Agency for Healthcare Research and Quality's (AHRQ) definition of BHI provides a useful starting point. It goes on to specify that, "This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization" (Peek and NIAC 2013). This broad definition can be used to characterize the many different approaches that practitioners have used to implement BHI and is notable for the fact that it is defined by the actual care provided instead of location of care (MACPAC 2016).

The journey to achieve BHI typically starts with initiatives that first coordinate external care then co-locate the care within primary care facilities, eventually integrating care (AHRQ 2011) (see Figure 1). For this reason, the AHRQ model is better thought of as a roadmap toward integrated care instead of a descriptor of the actual spectrum of integrated care activities.

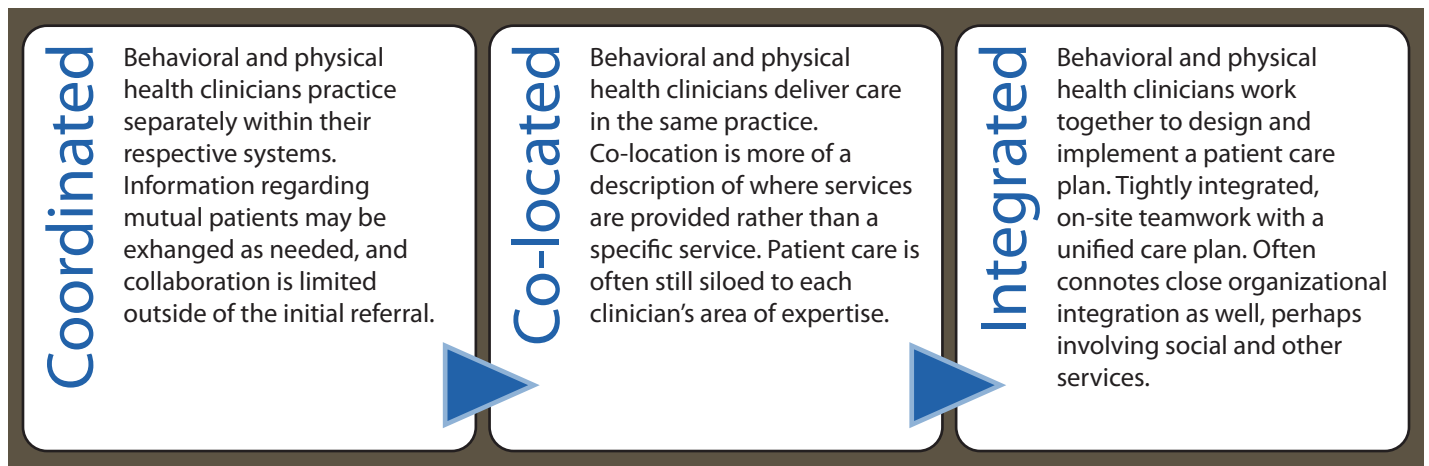


Figure 1: AHRQ Behavioral Health Integration Continuum (AHRQ 2011)

The Comprehensive Primary Care Initiative

The Comprehensive Primary Care initiative was a four-year multi-payer Center for Medicare & Medicaid Innovation (CMMI) initiative, piloted in seven regions across the United States from October 2012 to December 2016. CPC led to a new model in 2017—the Comprehensive Primary Care Plus (CPC+) initiative. As part of this initiative, primary care practices were engaged in supporting the provision of a core set of five comprehensive primary care functions: 1) risk-stratified care management, 2) access and continuity, 3) planned care for chronic conditions, 4) patient and caregiver engagement and 5) coordination of care across the medical neighborhood. As a strategy to the provision of risk-stratified care management, practices chose to integrate one of three advanced care management strategies: behavioral health services, medication management or self-management support. Of the over 400 participating CPC practices, 124 chose to focus on BHI (see Figure 2) as an advanced primary care strategy (CMMI Fast Facts 2015). To share actionable lessons learned from BHI within this initiative, this white paper presents CPC case studies and key elements for consideration by practice teams in their journey toward BHI.

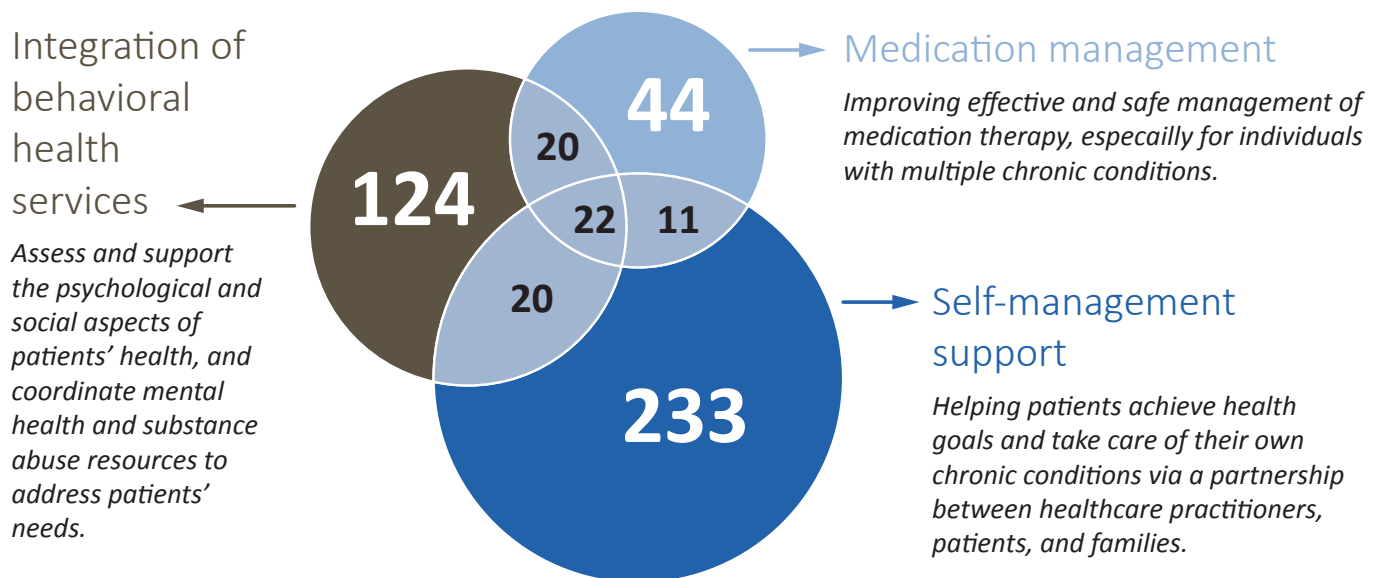


Figure 2: CPC Practice Selection of Advanced Primary Care Strategies (CPC Mid-Year 2015 Snapshot)

CPC Change Tactics for Integrating Behavioral Health

As part of their work in BHI, CPC practices were encouraged to implement the following change tactics:

- Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services
- Use evidence-based treatment protocols and treatment to goal where appropriate
- Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment
- Ensure regular communication and coordinated workflows between primary care and behavioral health providers
- Use a registry or electronic health record (EHR) registry functionality to support active care management and outreach to patients in treatment
- Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible

Behavioral Health in CPC

CPC practices reported overall that BHI increased practices' 1) awareness of patients' emotional and psychosocial needs and 2) capacity to engage patients in necessary behavioral health care. CPC practices also reported challenges specific to BHI, including identifying the appropriate patients to refer to behavioral health services and a lack of behavioral health providers with appointments available to whom patients can be referred. CPC practices that are physician owned and not part of a health system or in less populated areas identified a need for improved access to behavioral health specialists.

Effective behavioral health strategies are highly dependent on the specific needs of the practices' patient population, providers and practice environment. To help providers understand the various approaches and determine a course of action that will work in each specific practice, actionable lessons learned from BHI within CPC are shared below.

CPC Case Studies

Coordinated Care: Using Behavioral Health Care Compacts

Care compacts are a collaborative agreement developed between a primary care provider and specialist to provide a framework for better communication and safe transitions of care between the two providers. Care compacts with other providers in the medical neighborhood improve patients' transitions by standardizing communication and collaborative care management. Effective compacts can help bridge seams of care for patients, providing the potential to improve care while reducing harm and costs. An independent internal medicine practice in Colorado with three physicians and one nurse practitioner created a care compact with a counseling center for behavioral health referrals. This care compact developed forms for release of information, a plan of care and guidelines for efficient communication between

the facilities. This coordinated approach has allowed the practice to move beyond the traditional hurdle of sharing confidential mental health notes by proactively obtaining patient consent for both of the organizations to share information and collaborate in care planning. The counseling center developed new forms for release of information, plan of care and communication between the facilities after which they established workflows to integrate the process. As a workflow, patients are referred to the counseling center and an open referral is flagged on the record. If the referral remains open after 30 days, the practice messages the patient

The CPC Implementation Framework for BHI required the practices to:

1. Identify and meet the behavioral health care needs of each patient and situation, either directly or through co-management or coordinated referral
2. Have a systematic clinical approach to identify, engage and assess patients needing behavioral health services
3. Measure how integrated behavioral health services affect patients, families and caregivers receiving these services and how these services improve care outcomes related to targeted conditions or diseases

through the portal or calls the patient to follow up. If the consultation is complete and communication to the primary care provider is pending, the practice faxes a medical records request to the counseling center and allows time for response. The practice continues outreach to the patient in 30-day increments as needed for completion of follow-up.

Moving from Co-Located to Integrated Behavioral Health

Behavioral health services at a New York medical group have evolved from a co-located strategy into a high-level, fully integrated delivery of behavioral health services. The medical group comprises nine physicians, one nurse practitioner, five physician assistants, one PhD candidate behaviorist and one health coach delivering care to 16,000 patients at eight practice sites. The behavioral health services include sharing the EHR, dedicated workspace, a steady work stream of coordinated care with care teams, assessment on behavioral health and co-morbidities following evidence-based guidelines, identifying risk and behavioral conditions that could affect outcomes, and the behavioral health consultant contributing to overall care. This group practice found that going from co-located services to integration involved a complex synthesis of multiple moving parts: finding the right providers, locating helpful resources to support the transformation work, refining workflows and measuring effectiveness.

In developing the workflows, finding the right scheduling balance to accommodate same-day availability, previously scheduled appointments, co-visits with behavioral health and warm handoffs with behavioral health providers were critical elements. The staff also tracked pre- and post-treatment depression and anxiety scores with the Patient Health Questionnaire (PHQ)-9 and Generalized Anxiety Disorder (GAD) 7, among other standard screening tools. About 65 percent of the patients receive treatment within the practice using shorter behaviorally focused sessions with the behavioral health consultant or health coach. According to medical group, fully integrating behavioral health into the primary care practice is a win-win for all; providers see patient engagement and progress, and patients are given the assistance they need to make a meaningful, effective plan toward change.

Embedding Behavioral Health Services and Measuring the Effectiveness

A large Colorado clinic with 22 physicians and one physician assistant across five clinic sites embedded a behavioral health specialist to manage behavioral health needs in two of the clinic sites (in addition to on-site care management services). Providers access a behavioral health specialist for immediate needs during a patient encounter, for warm handoffs and for consultations. The care teams refer patients to the behavioral health specialist if their evaluation shows a potential benefit from short-term, solution-focused treatment. Patients meet with a specialist in 30- to 45-minute sessions, up to three times over a six-month period. The practice refers patients with complex behavioral health needs, such as severe substance use, chronic and persistent mental illness or trauma recovery, to external providers.

CPC Process Measures:

- Number of patient visits with the behaviorist (for practices with a behaviorist on site)
- Number of patients receiving behavioral health care reviewed by the team
- Number of patients with an identified behavioral health concern referred for behavioral health care
- Screening for Clinical Depression and Follow-Up Plan (NQF #0418)

To evaluate the effectiveness of these behavioral health services, the clinic began gathering a baseline PHQ-9 measurement, then tracking the scores among patients with moderate and severe depression following direct treatment (generally after three visits). Early data showed 65 percent of all patients in direct treatment had improved PHQ-9 scores at re-measurement, and all patients with severe depression (PHQ-9 of 20 points or more) had an improved score. When behavioral health services were first offered, high demand created a four- to six-week waiting time for visits. The clinic reduced the number of scheduled visits from six to three to open slots for quicker access. If patients have continuing needs after completing three visits, they are referred to an external provider. The clinic has emphasized with external providers that timely communication about patient treatment is an important part of their behavioral health approach. Because of the success of BHI, the clinic is moving this model to other clinic sites with the highest volume of patients with the largest need.

CPC Outcome Measures:

- The average PHQ-9 score of patients with a depression diagnosis
- Number of patients with a PHQ-9 score > 14 (moderately severe or severe depression)
- Average GAD score in patients with an anxiety disorder
- Number of patients with a GAD score > 14 (severe anxiety)

Integrating Behavioral Health Specialists

An Oregon physician-owned independent practice integrated behavioral health specialists in two of its practice sites and worked with a licensed clinical psychologist as a subject-matter expert to help steer through community dynamics and form a feasible model by coordinating with local health plans. The integration of behavioral health specialists was done by matching reimbursements with clinical licensing standards. While not all payers in the area reimbursed for triage and care management, they did pay for assessment and therapy in the practice setting.

A licensed clinical social worker (LCSW) was hired for assessment and triage as well as to work with the clinic's care management team. Oregon licensing requirements allowed use of medical office assistants or medical assistants for administering behavioral screenings such as the PHQ-9 and SBIRT (Screening, Brief Intervention and Referral to Treatment). The behavioral health specialists record the PHQ-9 scores in the practice's EHR, allowing physicians quick feedback and input. If a referral is needed, the behavioral health specialist coordinates that as well as any care coordination services with the care management team. Follow-up and follow through assure the physician that patient needs are met appropriately and in a timely manner.

Lessons Learned in BHI

Although practices implemented similar change tactics in integrating behavioral health, a variety of customized approaches were utilized to achieve the vision of BHI within the capabilities of their practice and population. Interestingly, though, these variations in approach still led to the identification of key themes across virtually the entire cohort.

- **Hire the right people:** Traditional behavioral health specialists are rarely trained to work in the fast pace of a primary care clinic where frequent interruptions and flexibility to manage whatever comes in the door is important. Look for a provider who can support the team's ability to identify behavioral health conditions, provide Motivational Interviewing and triage and/or treat a variety of behavioral health conditions (including chronic medication conditions) in primary care using various formats including individual, telephonic or group.
- **Provider relationships:** Practices indicated that focusing on BHI strengthened relationships with behavioral health providers outside of the practice and ensured their patients more consistent and timely access to these services.
- **Access to resources:** Having access to certain types of providers and resources appears to make BHI more manageable. Large practices or systems may have access to these resources and the ability to contract or hire staff to fill these needs. Smaller practices worked across the medical neighborhood to identify community-based resources, and in some cases shared with other practices, further enhancing a collaborative environment (Peikes et al 2016).
- **Triaged interventions:** Recognizing the high volume of work already within the practices, a team-based approach was almost universally implemented. This approach leveraged staff such as medical assistants to perform screening activities for BHI, nursing interventions for behavior change and reservation of full care management services to an identified high-risk subset of the practices' patients.

"The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."

AHRQ Lexicon for Behavioral Health and Primary Care Integration

Next Steps for BHI

Primary care practices wishing to begin the journey toward BHI will be well-served by a few simple planning tips:

Step 1: Choose a BHI Model or Approach that Works for Your Practice

When choosing a BHI strategy, your practice should answer some basic questions, such as the following:

1. What behavioral health issues do we want or need to address based on the population?
2. What will be the scope of our BHI efforts (e.g., number of sites, practices, providers, patients)?
3. What services will we offer? To what services can we refer patients? How do we target resources to priority areas?
4. What strengths do we think our practice already has to facilitate behavioral health care?
5. What challenges do we anticipate in implementing behavioral health care?
6. What resources (both personnel and financial) do we have to devote to this effort at this time?

Depending on the answers to these questions, your practice may decide to start with a coordinated, co-located or integrated approach to BHI, or some hybrid of behavioral health services. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides many tools, including an easy-to-follow [interactive flowchart](#) that can guide practices on how to work through administration concerns, build a business case, recruit staff and test workflows.

Step 2: Determine the Financial Implications of the Strategy

The first step to ensuring a return is to understand your organization's unique financing structure. Examine your payer mix and learn what types of practice activities generate revenue. The practice should consider the following:

- If you are reimbursed primarily on a fee-for-service basis, you will generate more revenue by using your behavioral health specialist as a provider–extender, enabling more patients to see the provider for a billable visit each day.
- If your organization accepts full risk for patient costs, then ensuring your patients are taught how best to manage their behavioral health and chronic illness and avoid specialist or emergency room visits will likely provide a more robust financial return.
- If you're paid a capitated fee for primary care services, experimenting with alternative visit types (telephone, group) may maximize your ability to care for more patients.

Step 3: Have a Plan to Expand BHI Throughout Your Practice and Beyond

BHI is sustainable when integrated care becomes business as usual, and when patients and providers can't imagine their practice without behavioral health care. When evaluating your practice plans for expanding BHI, consider factors such as provider burnout, leadership support, implementing workflows and staff turnover. The BHI efforts that the practice starts with must be expandable, sustainable and replicable.

Behavioral Health Tools and Resources

The following is a listing of helpful tools and resources for BHI:

- [SAMHSA](#) – SAMHSA provides many tools, including an easy-to-follow [interactive flowchart](#) providing a BHI Quick Start Guide.
- [AHRQ Academy](#) – AHRQ Academy offers resources to advance BHI and fosters a collaborative environment for those working in the field.
- [Primary Care Team Guide](#) – *The Behavioral Health Specialist* is a practical guide for integration with tools and resources.
- [Patient Centered Primary Care Initiative](#) – This BHI resource library offers resources for implementation.
- [Using Data to Identify Patients with Behavioral Health Needs](#) – This 6-minute video case study from CPC explains how a practice in Oregon identified patients with behavioral health needs through data.
- [Integrating Advanced Primary Care Strategies: Behavioral Health and Meds Management](#) – This 9-minute video case study from CPC explains how one mid-sized Oregon practice implemented behavioral health and meds management.
- [Creating Effective Care Compacts with Behavioral Health Specialists](#) – This 5-minute video case study from CPC reviews care compacts with behavioral health specialists in an independent Colorado practice.

The Future of Behavioral Health in Primary Care

As payment models continue to shift from fee-for-service to value-based care, more providers will have the means to incorporate some form of behavioral health services in primary care. Moreover, it is predicted that addressing behavioral health needs in the primary care setting will become the standard of care, further driving the need for BHI. With about a third of U.S. adults presenting with co-occurring medical and mental health conditions and 68 percent of adults with diagnosed mental illnesses also developing medical conditions over their lifespan, the need for BHI will continue to grow (Terry 2016). Treating and improving the mental health status of the patient in order to treat co-occurring medical issues will continue to be a focus. Having behavioral health services integrated in the primary care office will expand holistic patient care while improving both mental health and chronic disease outcomes.

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About TMF

TMF Health Quality Institute focuses on improving lives by improving the quality of health care through contracts with federal, state and local governments, as well as private organizations. For more than 40 years, TMF has helped health care providers and practitioners in a variety of settings improve care for their patients. For more information about TMF, go to www.tmf.org.