Integrated behavioral health in a clinical primary care setting

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More than 50% of all counties in the United States do not have a licensed behavioral health provider.[1] Only six states are at or above the recommended 14.7 psychiatrics for every 100,000 patients.[2] Additionally, psychiatry is at risk of further shortages as doctors retire in the coming years. The specialty has one of the highest average provider ages in medicine: Of the 28,250 currently active psychiatrists, 59% are 55 or older, placing it third among specialties with older providers, just behind pulmonology and oncology.[3]

To maintain sufficient provider numbers, it is essential that the number of new psychiatrists increase through graduate medical education (GME). According to the Association of American Medical Colleges (AAMC), an average of 1,171 psychiatrists completed GME programs each year since 2017 for general psychiatry, with an estimated 6,844 psychiatrists completing GME programs through 2021.[4] With roughly 12,486 psychiatrists 55 or older, there is a potential in the near future that more psychiatrists will leave the specialty per year than enter, making it more difficult for states to meet the behavioral health needs of their citizens. Currently, only half of all states have 50% or more of their behavioral healthcare needs met, while alarmingly, some states have not even met a quarter of their needs.[5]

All of these concerns are heightened further by anxiety and depression on the rise amid the COVID-19 pandemic, including about half of all people in the United States reporting that the crisis hurt their mental health.[6]

THE NEED FOR INTEGRATED CARE

Primary care is often the entry point for behavioral care. In 2010, 20% of all visits to primary care physicians (PCPs) included at least one of the following behavioral health indicators: depression screening, counseling, a behavioral health diagnosis or reason for visit, psychotherapy, or provision of a psychotropic drug. Approximately 6% of visits for children under 12 and approximately 31% of visits for adults 75 or older were associated with behavioral health care (See Figure 1).[7]

The prevalence of behavioral health needs is exacerbated by about two-thirds (67%) of adults with a behavioral health disorder not receiving appropriate treatment.[8] Within primary care settings, depression goes undetected in more than 50% of patients, and 66% of PCPs report they are unable to connect patients with outpatient behavioral health providers due to a shortage of behavioral health providers and health insurance barriers.[9]

PCPs functioning as the entry point for behavioral health issues have varying skill and experience in accurately diagnosing patient conditions and often lack confidence in their ability to sufficiently address patients' concerns. The challenges experienced by PCPs due to the increasing number of patients presenting with behavioral health concerns may lead to provider burnout and can interfere with the overall clinic flow as providers spend significantly more time with patients than originally scheduled.[10]

EDITOR'S NOTE

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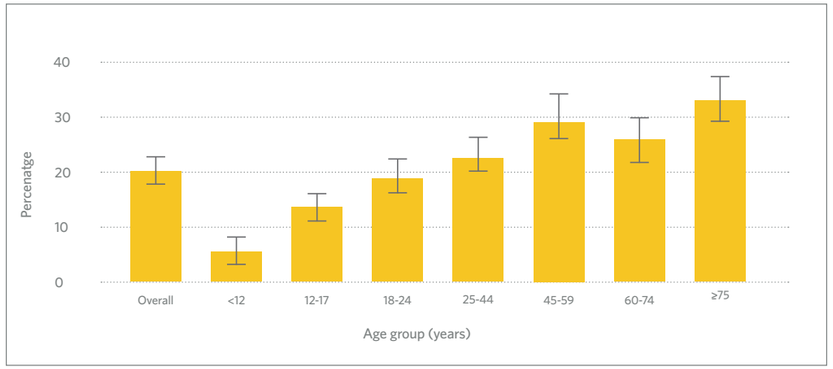
FIGURE 1. BEHAVIORAL HEALTH-RELATED PRIMARY CARE OFFICE VISITS BY AGE GROUP



INTEGRATED BEHAVIORAL HEALTH

To address overall health concerns, integration of behavioral health services into the clinical primary care setting is recommended to:

- Increase availability of behavioral health services within the medical model
- Provide support to the PCP in addressing patients' behavioral health needs
- Mitigate negative impacts on physical health
- Improve patient clinical outcomes and increase overall satisfaction with care through the integrated care model.[11]

There are three levels of behavioral health integration[12] within primary care:

1. **Coordinated**. In this first level of integration, behavioral providers and PCPs work within physically separate facilities and have separate health record systems. Providers communicate rarely about cases; if communication occurs, it is usually based on a particular need for specific information about a mutual patient.
2. **Co-located**. Behavioral providers and PCPs deliver care in the same physical location or practice. Patient care is often still siloed to areas of expertise. Due to the proximity of behavioral and primary care providers, there may be occasional meetings between providers to discuss mutual patients.
3. **Fully integrated**. Behavioral providers and PCPs function as a team, working together in the same physical space to design and implement a patient care plan. Providers understand the different roles team members play and structure the delivery of care to better achieve patient goals. Providers and patients view the clinical operation as a single system treating the whole person.

To sustain long-term success of an integrated behavioral health model, additional factors should be considered:

- **Structural integration**, which promotes common administrative authority leading to collaboration across disciplines
- **Financial integration** with common financial resources and oversight
- **Care team integration** in which additional health professionals (e.g., clinical pharmacists and care managers) are incorporated into the overall care team.

CASE STUDY

Data collected from January 2014 to February 2015 revealed that 41% of all attributed patients had a comorbid behavioral health condition within an academic medical center (AMC) primary care group. Provider surveys about treating these behavioral health conditions revealed six main challenges to the quality of the provision of care:

1. Limited provider resources for the management of psychotropic medication
2. Limited patient access to behavioral health providers due to contractual carve-outs and burdensome administrative processes

3. Limited behavioral health referral network for providers
4. Ongoing challenges for patients and providers when attempting to navigate the behavioral health system
5. Unfamiliarity with the limited overall community resources specifically for behavioral health issues
6. The breakdown of social systems as a result of behavioral health issues.

Based on provider feedback, group leadership decided to integrate behavioral health into the practice.

Steps to integration

The primary care group went through the stages of integration to coordinate, co-locate and fully integrate behavioral health. Initially, the goal was to provide a satisfactory level of integrated care between behavioral health providers and PCPs at the lowest overall cost to the group.

Coordinated. The group engaged care managers from the AMC-sponsored health plans to assist in the coordination of care for members at all clinic locations. This provided a starting point for PCPs to gain an understanding of services available within the community and the complexity of managed behavioral health services. This had limited success in the improvement of care for the specific subset of patients and provided marginal support for all other patients. After a year of implementing the coordinated care model, senior physician leadership determined that a new model was needed.

Co-located. The group then moved toward co-location by entering into a collaborative agreement with the AMC's college of nursing. Through this agreement, the group employed three psychiatric advanced practice registered nurses (APRN) at two of the system's largest clinics with the highest patient volumes. Over the two years in which this model was employed, the group did not realize the anticipated results. Difficulties identified included the APRNs functioning more along the line of private practitioners, not as active care team members. The APRNs operated with a long-term treatment philosophy which caused a new patient lag of three months or longer for the next available appointment. Additionally, there was minimal collaboration with mutually shared patients due to the exclusive behavioral health focus of the APRNs. Because they were involved in long-term therapy sessions, the APRNs weren't available for crisis intervention or medication consultation. These challenges did not reduce the burden of care on the PCPs nor provide adequate coordinated care for patients.

PRACTICE FACTS

- Primary care practice within a large academic medical center
- 165 physicians and advance practice providers (APPs) in 12 clinics throughout a metro area

Reevaluation, full integration and embedment. After two years of the co-located model, senior physician leadership chose to move to a fully integrated and embedded behavioral health and primary care model. Leadership visited two established behavioral health integration programs to gain insight and understand structure of successfully integrated practices. From these visits and conversations with program leaders, it was determined that licensed clinical social workers (LCSW) would be the optimal provider type, from a cost containment and potential revenue perspective. The next step in the transition to full integration was to recruit an LCSW as manager of the integrated program. The manager was responsible for recruiting new LCSWs to the program, determining clinical workflows, addressing any personnel issues and serving as a liaison between the LCSWs and group leadership. Under the direction of the manager, the group hired four experienced LCSWs to practice in the four largest clinics. The group also partnered with the AMC's school of social work to have four students work with the four LCSWs. All LCSWs were tasked with building relationships with PCPs, being flexible in their schedules, being visible and embedding themselves within the clinic, and being available for ad hoc consultations. Because of payer limitations and behavioral health carve outs, LCSWs did not initially charge patients for services rendered to remove any barriers for patients to receive comprehensive and holistic care. Full funding for the cost of the LCSWs came from clinical revenue generated by the primary care group and was viewed as an investment in patient care and provider well-being. The model was deemed a success, as it reduced the burden of care on the PCPs, provided a higher level of coordinated care for the patient and resulted in overall improvement of quality metrics for patients with comorbid conditions. The group recruited additional LCSWs to provide integrated care at all clinic locations.

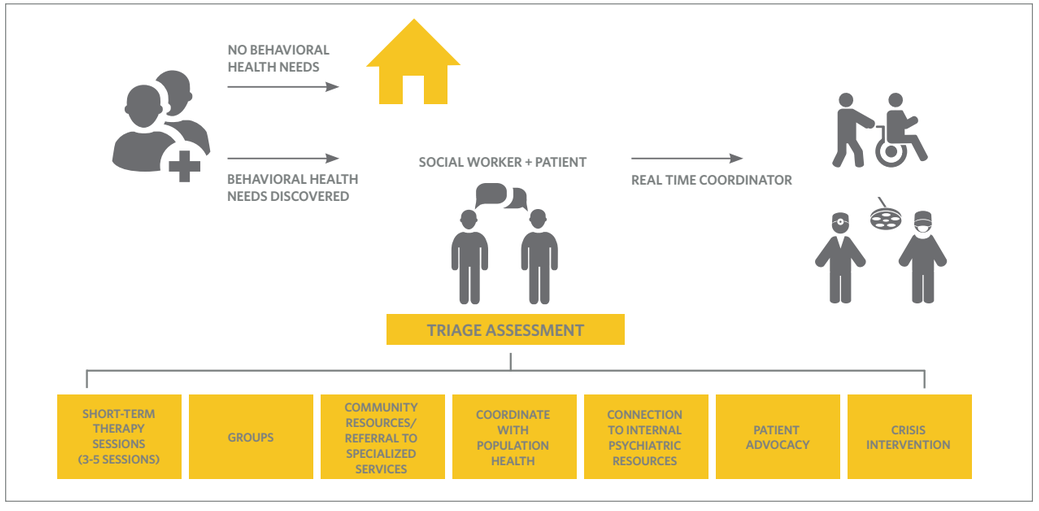
Care team model. The group incorporated LCSWs into its overall care team model with the goal of improving the comprehensiveness, coordination, efficiency and value of care, as well as improving patient and provider satisfaction and eliminating waste, financially and operationally.[13] (See Figure 2 for specific roles on the care team.)

Behavioral health process flow. The integration of behavioral health services occurs in the course of regular clinic flow (See Figure 3). If during the scheduled visit the patient expresses behavioral health needs or if the PCP discovers a need through conversation or observation, the LCSW can be brought into the exam room to conduct a "warm handoff." During the warm handoff, the PCP introduces the patient to the LCSW and explains the LCSW's role and function as a member of the care team. The PCP can then wrap up the visit with the patient, handing off to the LCSW and continue attending to scheduled patients. The LCSW can perform a brief triage assessment and determine the best level of care and appropriate interventions for the patient. Based on clinical indications, interventions can include the following:

- **Short-term therapy sessions**: solution-focused, brief interventions designed to identify social/psychological barriers to the treatment, prevention and management of physical health problems

FIGURE 2. MEMBERS OF THE PRIMARY CARE TEAM

FIGURE 3. PROCESS FLOW FOR INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE



- **Group intervention**: short-term therapy sessions involving groups of five to seven patients with common conditions
- **Community resources/referral to specialized services**: LCSWs assist in connecting patients to a variety of specialized community resources, such as housing assistance, transportation assistance, food assistance, etc.
- **Coordinate with other care team members**: LCSWs facilitate patient introduction to other members of the care team.
- **Connection to psychiatric resources**: Depending on the need of the patient, LCSWs may coordinate referral to psychiatric resources within the community.
- **Crisis intervention**: If a patient in clinic is a clear and present danger to themselves or others, the LCSWs will provide immediate crisis intervention up to and including recommendation to admit to a psychiatric facility.

KEY LESSONS LEARNED

The group's integration plan yielded these key steps for success:

Establish the mission of integration. Both primary care and behavioral health leaders and stakeholders need to establish a shared vision of integration and create a mission statement that clearly and concisely articulates the guiding purpose of the model and lists desired outcomes.[14] Leaders need to be committed to the concept and philosophy of integrated care.[15]

Collaborate to develop shared solutions. All involved stakeholders should meet regularly during early implementation to discuss the needs and challenges of integration and celebrate successes and progress.

Measure outcomes. Identify meaningful metrics (e.g., number of warm handoffs per month, number of depression screenings, etc.). Develop an effective distribution method of timely reporting. Periodically review metrics to track progress, identify barriers and answer key performance questions.

Be deliberate in recruitment. Hiring the right providers is crucial. Not all healthcare and behavioral health providers are suited for the model. The main characteristics of successful providers include honesty, discipline, creativity, humility and curiosity.[16] Providers need to be team players, flexible and internally motivated. For behavioral health providers, the ability to adjust and adapt to the fast pace of primary care is crucial: They need to be comfortable moving from exam room to exam room, be open to interruptions during the day and be available for warm handoffs as needed.

ONLINE EXCLUSIVE

For a detailed behavioral health intervention process flow, including warm handoffs, brief mental health assessment, recommendations based on triage assessment and more, visit the online version of this article: **mgma.com/huggard-behavioral**.

Sufficient funding. It is vital to have complete buy-in from primary care leadership. Because the startup costs and ongoing maintenance cost of the model are not insignificant,[17] leadership must have a clear understanding of the need for integration and fully support the model. Groups should research grants and governmental support opportunities and thoroughly understand billable services, such as Health Behavior Assessment and Intervention (HBAI), to provide funds to offset startup and operational costs.

It is recommended that practices consult with the local Medicare Administrative Contractor (MAC) to better understand coverage, eligible billing providers and specific reimbursement rates before providing HBAI. The codes and their assigned RVUs used for calculating Medicare fees are listed in the Medicare Physician Fee Schedule.

ADDITIONAL CONSIDERATIONS

Data. Data for the group is limited to the number of HBAI and warm handoffs by location and by provider each month, which is sufficient for the immediate goal of increasing the number of PCP referrals and number of interventions provided. However, to demonstrate the value of social work in primary care, the leadership wants to be able to tie HBAI interventions to positive clinical patient outcomes, such as lowered hemoglobin A1c for patients with diabetes and lower blood pressure for patients with hypertension. Social work interventions also could help demonstrate lower overall cost of care and increased patient satisfaction in the transition to value-based reimbursement.

Promoting social work within primary care. To obtain buy-in from PCPs, it is important to emphasize the assistance social work can provide for complex patients with psychosocial issues affecting disease outcomes. Physicians do not have time within the patient visit to address all physical and psychosocial issues. In the case study, providers initially were slow to refer patients to social work due to unfamiliarity of interventions provided, lack of professional connection to the social worker and history of addressing and treating psychosocial issues themselves as part of patient care. Through education efforts during provider meetings, social workers in the case study increased referrals for HBAI 57% in a year.

Financial benefits. Demonstrating quality improvement and cost reduction will be vital as reimbursements shift from fee-for-service to value-based payments. The following data summarize the potential financial benefit of integrated behavioral health as recognized by organizations currently deploying the model:[18]

- Use of healthcare services decreased by 16% for those receiving behavioral health treatment, while it increased by 12% for patients who were not treated for their behavioral health care needs.
- Depression treatment in primary care for those with diabetes had $896 lower total healthcare costs over 24 months.
- Depression treatment in primary care had $3,300 lower total healthcare cost over 48 months.
- Annual medical expenses — chronic medical and behavioral health conditions combined — cost 46% more than those with only a chronic medical condition. ■

Hiring the right providers is crucial. The main characteristics of successful providers include honesty, discipline, creativity, humility and curiosity.

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