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Integrating Behavioral Health into Primary Care

Best Practices and Learnings

bi3 Learning Series
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Summary

More than one-quarter of adults in the U.S. experience a behavioral health concern each year.[1] For those seeking help, the first stop is often a primary care provider. Yet, many primary care providers lack resources to provide the type and level of care needed, which can affect both mental and physical health outcomes. Beyond common treatments for diagnosed mental health disorders, patients need support for a wide range of behavioral health needs, including lifestyle changes to better manage chronic disease and mental well-being.

Primary care providers at TriHealth, bi3's partner healthcare delivery system in Greater Cincinnati, have long identified mental health as a key focus area for improving adult patient care. Change is hampered by the fact that often, there is no clear referral path for patients due to the limited number of mental health providers and other barriers to access. Even with a successful referral, there may be limited communication between the patient's providers, further isolating mental healthcare options.

As an invested partner in TriHealth, bi3 sparks innovation by funding the development of new care models that enable TriHealth to think differently about population health solutions and deliver value-based care.

In 2015, bi3 awarded a $3.3 million grant to TriHealth to identify and implement a patient-centered approach to integrate behavioral health into primary care practices.

Goals of the Four-Year Initiative

1. Identify better ways to connect primary care patients to mental and behavioral healthcare
2. Build the capacity of behavioral healthcare within an existing healthcare system
3. Improve support for primary care providers to increase job satisfaction
4. Deliver measurable improvement in patient health
5. Scale and sustain the mental healthcare services within the healthcare system

This bi3 Learning Series Paper details how the approach can work. During the grant period, patients in the TriHealth Behavioral Health Integration Project showed improved mental and physical health scores, while 95 percent of participating primary care physicians reported increased job satisfaction and improved ability to meet patient needs. Equally important, the project allowed TriHealth to explore, implement and refine an integrated approach to supporting patients' behavioral health needs. **Patient access to same-day visits continues to be one of the most beneficial components of integrated behavioral health.**

Today, TriHealth continues to build its capacity to make these services available at each of its primary care practices by 2022.

In addition to producing positive outcomes, the Behavioral Health Integration Project generated important lessons for the integration of behavioral health services within primary care. Among them, the Project identified a regional shortage of behavioral health consultants and challenges in culture and adoption when bridging these two fields.

[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication. Arch Gen Psych. 2005;62:617-27.

The project also spurred unique collaboration among regional competing health systems and organizations. Representatives came together to engage in shared training and roundtable discussions benefitting the entire community.

An Urgent Need to Integrate Behavioral Health

Overwhelming Behavioral Health Needs Evident in Primary Care

In a 2015 needs assessment of TriHealth primary care physicians, approximately three-quarters reported seeing patients with unmet behavioral health needs within the last two days. Physicians defined five percent of their patients' needs as "urgent" and 20 percent as "pressing." In January 2016, a three-year review of 269,000 TriHealth primary care patient records found that 64 percent had at least one existing chronic disease diagnosis, 41 percent had at least one existing mental health diagnosis and 32 percent had both.

Primary care providers serve as a de facto mental healthcare system[2] in the United States and are typically the starting point for mental healthcare. However, significant barriers exist for traditional primary care providers to address the behavioral health needs of patients, including stigma, cost and the lack of resources to help patients once mental and/or behavioral health needs are identified. A shortage of behavioral health providers and access barriers result in increased pressure on primary care physicians to diagnose and treat mental and behavioral health problems for which they are often not adequately trained.

The Need is Evident

- About 1 in 8 Americans report taking antidepressants in the previous month, and antidepressant usage has increased nearly 65 percent in the last 15 years.[3]
- Approximately half of individuals who died by suicide did not have an identified mental health condition.[4]
- Only 10 percent of patients will follow up on a referral to a mental health provider that is not co-located in the primary care office,[5] indicating a referral-based system is not the answer.

Movement from Sick Care to Health Care

Engaging patients to become active participants in managing their health often requires changing thoughts and behaviors. Behavioral factors are estimated to contribute to up to 40 percent of premature death causes.[6]

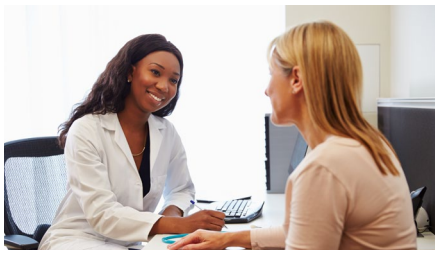
[2] Xierali IM, Tong ST, Petterson SM, Puffer JC, Phillips RL, Bazemore AW. Family physicians are essential for mental healthcare delivery. J Am Board Fam Med. 2013;26(2):114-115.

[3] Pratt L,Ph.D., Brody D., M.P.H., and Gu Q., MD. Antidepressant Use Among Persons Aged 12 and Over: United States, CDC 2011-2014.

[4] Stone D., ScD1, Simon T., PhD, Fowler K., PhD; Kegler S., PhD; Yuan K., MS, Holland K., PhD; Ivey-Stephenson A., PhD; Crosby A., MD. Vital Signs: Trends in State Suicide Rates-CDC United States 1999-2016 and Circumstances Contributing to Suicide-27 States, 2015.

[5] Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). Evolving models of behavioral health integration in primary care. New York, NY: Milbank Memorial Fund.

[6] Shroeder S., MD. We Can Do Better-Improving the Health of the American People. NEJM, 2007.



The relationship between physical and mental health underlies the *2014 Patient-Centered Medical Home Standards and Guidelines* issued by the National Committee for Quality Assurance. A key tenet states that primary care practices need to have integrated assessment systems in place for mental health, substance abuse and poor health habits, as well as resources for mental health treatment and care management.

Integrated behavioral health has been a component of armed service and community mental health systems for years but has not been common in healthcare system primary care practices. Now, evolving care standards, payment reform and a focus on population health and value-based contracting are driving efforts to integrate behavioral health services into health systems.

The Result: Identifying patient mental and behavioral health needs is rapidly becoming a required quality metric for improving population health.[7]

Identifying and Implementing the Right Model

The 2015 bi3 grant to TriHealth supported the identification and implementation of a model to integrate behavioral health into primary care. TriHealth selected Mountain View's *Primary Care Behavioral Health Model (PCBH)* to pilot in five primary care practices whose patients' insurance patterns averaged 20 percent Medicare, four percent Medicaid and 67 percent commercial insurance.

Design Elements:

- **Behavioral Health Consultants (BHCs):** A psychologist or licensed independent social worker (LISW) is the key position that the model embeds into the primary care team. BHCs are fully integrated on-site and participate in scheduling, team huddles, debriefs and shared visits.
- **Brief, Solution-Focused Intervention:** Patient assessment and engagement are brief (average one-six patient visits), productivity is high (BHC has between eight and ten, 30-minute appointments per day), and interventions are problem-specific and evidence-based (focusing on improving self-management skills and functioning).
- **Primary Care Providers as Customers:** The BHC role supports the primary care provider by offering on-demand consultation and receiving same-day patient referrals. BHCs enhance communication between patient and physician and improve the physician's understanding of challenges in patients' lives.
- **Standardized Pathways of Care:** Remove subjectivity of BHC referrals by developing standards based on identified disease states or diagnoses of chronic illnesses, such as the onset of diabetes or concerns about anxiety.
- **Patient-Centered Services:** Patients have multiple options to address their needs beyond meeting with the BHC, including health coaching sessions via phone; in-office primary care groups for high-need conditions (e.g. insomnia, chronic pain); chronic disease self-management workshops; and referrals to other community resources. For patients with serious mental health issues, the BHC provides a warm handoff to a TriHealth psychiatrist.

[7] Robertson, R.,PhD, Reiter J.,ABPP. Behavioral Consultation and Primary Care—A Guide to Integrating Services, 2nd Edition

Complementary Funding: In addition to bi3 funding, TriHealth's participation in the Center for Medicare and Medicaid Services alternative payment model—Comprehensive Primary Care Plus (CPC+), which identified behavioral health integration as a key tenet of primary care—allowed the behavioral health model to expand into five additional practices.

> "Having behavioral healthcare within our practice opens up so much for patients and physicians. It gives physicians more power to help patients, to understand them better and to understand the behavioral health concerns which affect their functioning. It opens up our time, gives us the support of a team and provides options besides medication, such as helping the patient to develop coping skills."
>
> – Jennifer Messer, MD, TriHealth Northcreek Family Practice

Outcomes and Results

The integration of behavioral health services into adult primary care practices increased access to care, fueled better health outcomes and improved provider satisfaction. Patient access to same-day visits continues to be one of the most beneficial components of integrated behavioral health.

Since Implementation Began in 2016:

More than **12,000** patients have been referred to BHCs. Those patients completed 19,500 appointments with an additional 2,227 in-office referrals not billed for the first visit (made possible by bi3 funding). These brief contacts allow the BHCs to introduce services, refer to additional care services and provide continuity visits and relapse prevention.

More than **819** patients have been referred to consultative psychiatry with 1,817 completed appointments.

430 patients have completed in-office psychoeducation groups to improve sleep, anxiety, depression and chronic pain. 120 have participated in chronic disease self-management classes.

Data shows access to **behavioral health services** has improved in practices with an embedded behavioral health consultant. In TriHealth's practices without embedded services, zero to three percent of patients received a behavioral health referral. In contrast, six to 18 percent of the patient panel received a behavioral health referral in those practices with embedded services.

Patient Outcomes (from 3,152 patients)

- 61 percent of patients demonstrated improvement in mental health*
- 50 percent of patients demonstrated improvement in physical health, including weight loss and lowered blood pressure*
- Patients rated "helpfulness of the BHC visit" an average 9.3 on a 10 point scale

*As measured by the PROMIS 10

Provider Outcomes (from 65 providers; 67% response rate)

- 97 percent were satisfied with BHC services
- 92 percent saw improved job satisfaction and 95 percent saw improved ability to manage patient needs
- 81 percent are more likely to recommend non-pharmaceutical interventions
- 86 percent are more likely to recommend behavioral health strategies directly to patients
- 90 percent are more comfortable and less stressed treating patients with significant health concerns or who are in crisis
- 90 percent reported patients were offered appointments with a psychiatrist faster than in community systems
- 71 percent were satisfied with virtual psychiatry consultation

> "I feel so much support. I feel less lonely. I feel like I am taking charge of my life. I am learning to listen to my body and retraining my thinking and actually applying it in everyday life."
>
> – Behavioral Health Patient of TriHealth

Collaborative Learning with Competing Healthcare Systems. Over the course of TriHealth's project implementation, other local community-based mental health organizations and healthcare systems subsequently deployed the Primary Care Behavioral Health Model. Despite the competitive environment, the organizations engaged in shared training and roundtable discussions to support the delivery of high-quality services in the community. The grassroots collaborative work was featured at the statewide Ohio Patient-Centered Primary Care Collaborative meeting to an audience of providers, payors and patient-serving organizations.

Lessons Learned

In addition to producing positive outcomes, the Behavioral Health Integration Project generated important lessons for behavioral health and primary care:

1) Addressing a Shortage of Behavioral Health Consultants: There is a limited pool of independently licensed clinicians in the Cincinnati region. Recruitment and hiring of BHCs are further challenged because of the unique skill set and credentialing required for both commercial and Medicare insurance

reimbursement in an integrated care environment. To address the need, TriHealth established partnerships with local universities to develop curriculum and internships to build a pipeline of potential candidates for future open positions. Prior to the COVID-19 pandemic, TriHealth began piloting telehealth to test virtual visits through a same-day handoff from primary care providers to a remote BHC. However, there were limitations on how and which patients BHC's could reach virtually. The crisis resulted in the removal of many of those restrictions, creating an opportunity to expand behavioral health services usage and increase availability at additional sites. Importantly, the new guidelines allow the telehealth services to be reimbursed through most payors.

2) Reducing Turnover: To better support behavioral health consultants (BHCs) by combating isolation and reducing turnover, TriHealth developed a robust on-boarding process that includes didactic training, shadow opportunities with primary care providers and experienced BHCs, and ongoing mentoring and professional development. BHCs can reach out to other team members via secure instant messaging to help with questions and provide resources to best meet the needs of patients.

3) Managing Lack of Uniformity in Reimbursement for Behavioral Health Services: Reimbursement for behavioral health services is universally low, while reimbursement and benefits vary greatly among payors. Behavioral health benefits often have higher specialty copays, are "carved out" from health benefits and have different benefit managers. Seeing both the primary care provider and BHC in the same day for a behavioral health concern, such as depression, can result in two charges to the patient. To reduce these potential barriers, TriHealth waived the fee for same-day first appointments. TriHealth is exploring alternative payment arrangements with the following goals:

a. Improve reimbursement for services
b. Identify opportunities to increase use of BHC services
c. Drive down inappropriate patient-directed utilization of healthcare system resources

4) Defining Roles and Workflow: Defining how BHCs embed in practices—from what space is available to meet with patients, to where behavioral health fits within a primary care practice—are ongoing challenges for implementation. All team members within a practice must be comfortable identifying patients who would benefit from behavioral health services and engaging the patient by introducing BHC services. The BHC must be proactive in developing relationships, reviewing schedules to identify appropriate patients, maintaining communication with busy providers and helping the practice meet population health goals.

5) Gaining Physician Buy-in and Adoption: Integrating behavioral health services into primary care is an enormous culture change. Each field—behavioral health and primary care—has its own approach to patient care and outcomes. Bridging these two fields takes time, trust and tenacity. Despite overwhelming endorsement of the need for integrated behavioral health, providers adopted this new model at varied rates, and referrals lagged behind expectations. While some providers were early champions, others needed time, experience and evidence that the model worked for patients and for their practices.

6) Building a Business Case for Integrated Behavioral Health: The greatest challenges to proving the business case for behavioral health integration are the lack of consensus on what outcomes to measure and the inability to isolate and monetize specific cost savings associated with improving behavioral health access. Many healthcare models look to a reduction in emergency room visits as a measure for population health and value-based contracts. However, a three-year review of TriHealth emergency room admittance placed mental and behavioral disorder diagnoses at only three percent of visits. While the number of visits has decreased over time, the percentage of visits for mental and behavioral disorders has remained static.

There is also no data capturing underlying patient or population behavioral health diagnoses when a patient visits for other conditions. With 60 percent of primary care patients having at least one chronic disease, many of which are behaviorally influenced and preventable, it is important to have consensus and select appropriate metrics to define success of integrated behavioral health.

Refine. Scale. Sustain.

TriHealth continues to refine the model and identify strategies to scale and sustain integrated behavioral health services. bi3 has committed funding to scale the model to new practice locations. While reimbursement for behavioral health services continues to lag behind care costs, there may be opportunities to leverage fee-for-service payments to support the full range of integrated behavioral health services, including consults with BHCs and psychiatrists.

TriHealth's expansion of primary care practices into the Comprehensive Primary Care Plus (CPC+) payment model resulted in additional committed dollars and a greater requirement to support behavioral health services in primary care practices. TriHealth plans to expand the Primary Care Behavioral Health Model to all 38 of its CPC+ practices by 2022. Expansion of BHC services across the practices will be incremental and will be based upon multiple criteria, including but not limited to the number of patients assigned to the practice; the number of primary care providers in the practice; geographic location; physical space available; and physician support.

Integrating behavioral health into primary care continues to promise easier access and improved outcomes for patients. The TriHealth Behavioral Health Integration Project achieved these outcomes and generated important lessons for others striving to make behavioral health an essential part of the healthcare continuum.

bi3 Bethesda Inc.'s grants initiative to *transform* health

Acknowledgments

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About bi3

bi3 is Bethesda Inc.'s grantmaking initiative to transform health in Greater Cincinnati. Bethesda Inc., in partnership with CommonSpirit Health, is a co-sponsor of TriHealth, Greater Cincinnati's largest integrated health system.

bi3 invests in innovative ideas with the ability to spark and scale new approaches to improving community health and healthcare.

Since 2010, bi3 has made more than $48 million in grants to fund innovative ideas to transform health and healthcare, ranking it as one of Ohio's largest health-focused funders. Our work has helped reduce Cincinnati's infant mortality rate, increase access to better care, elevate the importance of planning for end-of-life care and leverage additional funding to spread successful efforts to transform health.

Learn more at **bi3.org.**