



# THE CASE FOR TREATING THE WHOLE PERSON IN THE AGE OF HEALTH CARE REFORM

## Lessons from the Integrated Behavioral Health Project

### Introduction

In recent years, growing numbers of governmental agencies, academics and practitioners have recognized the connection between mind and body in patient care. As Pamela Hyde, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), said recently, “we can’t have a healthy America without having good behavioral health.”

Communities across the country have been integrating “behavioral health” – defined here as mental health and substance use – with primary medical care to improve patient outcomes and control costs – in essence, to reattach the head and body. This coordinated effort brings together medical and behavioral health providers to detect, treat and follow-up behavioral and physical disorders in the most appropriate setting to care for patients.

Since 2006, the Integrated Behavioral Health Project (IBHP) has been working to accelerate those efforts in California. Its goals are to increase access to behavioral health services, reduce the stigma associated with seeking such services, improve patient outcomes, and strengthen collaboration between behavioral health and primary care providers.

Integration poses challenges at the clinical, operational and financial levels--challenges that can be overcome. Breaking out of the long established health care silos requires commitment--as well as the financing and policy reforms to help create and sustain the coordinated efforts. As all health care is local, there is no one-size-fits-all approach to integration. However, IBHP clinic projects and other models demonstrate that it can be done. Promising approaches of integrating behavioral and physical health care show that there are practical ways to treat the whole person and reduce costs.

The time is now. The healthcare environment is changing in ways that create unique opportunities to make integration a reality. The Affordable Care Act will place a greater emphasis on the ability to demonstrate quality outcomes and manage costs, and will create significant changes in coverage, delivery system design and payment reform. These changes make behavioral health-primary care integration more important than ever.

In this paper, IBHP explores why integration is necessary and what it will take, offers lessons learned from its grantees and field-building work, and presents implications for the practitioners, policy makers and funders who can influence this arena.

### The IBHP Approach

Launched in 2006 by the Tides Center and funded by The California Endowment, IBHP has been working to enhance access to behavioral health services and improve outcomes in primary care community clinics throughout California ([www.ibhp.org](http://www.ibhp.org)).

Based on its experience over the four-year initiative, which concluded in June 2010, IBHP recommends several strategies for health systems, government or foundations that are interested in furthering the knowledge and practice of integrated care<sup>1</sup>:

- 1 Invest in vanguard clinics to promote their leadership and demonstrate their role as vital health and behavioral health service providers in communities**
- 2 Establish a learning community committed to knowledge transfer and dissemination through conferences, monthly trainings and technical assistance from state and national experts**
- 3 Serve as a dissemination portal (through a clearinghouse website, consultative support and referrals) for resources, training materials and research findings related to the impact and effectiveness of integrated behavioral health**
- 4 Develop strong partnerships and collaborations to create a policy environment that supports and encourages expansion of integrated behavioral health by eliminating financing, IT, and workforce barriers, and promoting a change strategy focused on enhanced access, stigma reduction and improved client outcomes**

## The Need to Integrate

### RESEARCH DEMONSTRATES SIGNIFICANT INTERPLAY BETWEEN CHRONIC ILLNESS AND DISABILITY, AND MENTAL HEALTH.

Behavioral disorders affect millions of people and can take an enormous emotional, physical and economic toll if left untreated.

- Montreal researchers found depressed heart patients were four times as likely to die within six months after having a heart attack as those without depression
- Mental health problems are 2 to 3 times more common in patients with chronic medical illnesses such as diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease; moreover, a high proportion of them never have their psychiatric condition diagnosed or treated (Milliman 2008)
- Type 2 diabetes, a condition frequently managed within primary care clinics settings, nearly doubles the risk of depression; an estimated 28.5 percent of diabetic patients meet criteria for clinical depression
- Nearly half (49 percent) of Medicaid beneficiaries and more than half (52 percent) of dual eligible Medicaid/Medicare beneficiaries with disabilities have a psychiatric illness.<sup>2</sup>

At the same time, people with serious mental illness die on average 25 years earlier than the general population primarily as a result of untreated or unmanaged medical conditions. These patients often get care in the mental health system, which is ill-equipped to treat other medical conditions.<sup>3</sup> Bidirectional integrated care – care that recognizes the health needs among people with behavioral health disorders who seek care primarily in the mental health system as well as recognizing the behavioral health needs of patients in the primary care system – can better connect patients within the mental health care setting to a full scope medical home for more complex care.

### MENTAL HEALTH DISORDERS, INCLUDING DEPRESSION, COMPRISE ONE OF THE FIVE MOST COSTLY HEALTH CARE CONDITIONS.<sup>4</sup>

Beyond the human toll of untreated mental health conditions, they result in higher health care costs. In addition to the cost of treating the behavioral health condition itself, treating chronic and physical conditions as well are more expensive when there is an untreated co-occurring mental health condition. Specifically:

- Adults with coronary artery disease and depression have \$5,700 higher direct annual medical costs than those without anxiety or depression
- Depression is associated with poor glycemic control, increased risk for complications, functional disability and overall higher healthcare costs in diabetic patients
- One-quarter of admissions to hospitals has something to do with mental health or substance use<sup>5</sup>

## Integration is Cost-Effective

### NUMEROUS PROVEN INTEGRATED APPROACHES AND PROTOCOLS HAVE BEEN SHOWN TO IMPROVE HEALTH STATUS AND REDUCE TOTAL HEALTH CARE EXPENDITURES.

Because primary care is often the first or only access point for many patients, integration offers the opportunity to intervene early, prevent more disabling disorders and reduce costs. Potential cost savings from integrating behavioral health and primary care are striking.

- Assuming that integrated medical-behavioral care can produce a 10 percent reduction in the excess healthcare costs of patients with co-morbid psychiatric disorders, savings of \$5.4 million can be achieved for each 100,000 insured members
- Depression care management for Medicaid enrollees can reduce overall healthcare costs by \$2040 per year with impressive reductions in emergency department visits and hospital days
- A Kaiser Northern California study showed that those who receive substance use treatment had a 35% reduction in inpatient costs, 39% reduction in emergency room cost, and a 26% reduction in total medical cost, compared with a matched group
- Implementation of the IMPACT program for treating depression in patients with diabetes in primary care resulted in lower overall general medical care costs of \$1100 per individual per year, even after including the costs of investing in the depression treatment

## Core Elements of Integrated Behavioral Health Care

**CLINICAL INTEGRATION HELPS FOCUS ON WHAT PEOPLE NEED AND REQUIRES FINANCIAL AND STRUCTURAL SUPPORTS TO BE SUCCESSFUL.**

In integrating care, the important factor is not which “roof” care is delivered under, but how. There must be close coordination and collaboration between behavioral health and medical service providers, ideally resulting in a seamless continuum of care for clients. Breaking down the current silos and bridging cultural differences in the practice of health care is at the core of integrated care.

Financial or structural integration alone does not assure clinical integration. Public sector efforts focused solely on financial integration or so-called “carve-ins” have had limited success. Rather, integration must occur across three dimensions: clinical, financial and operational.

To help define what successful integration looks like, IBHP developed a matrix of essential components of integrated care. The California Behavioral Health Technical Workgroup, convened to inform the development of the state’s Section 1115 Waiver application, endorsed the matrix (see chart below). A framework developed by the integration policy initiative can be used as a planning tool for developing an integrated system and assigning roles and responsibilities.<sup>6</sup>

## Lessons Learned

Serving largely those patients with low behavioral complexity and a range of physical health conditions, IBHP clinics demonstrated consistent findings of improved outcomes. Lessons learned and best practices that emerged from their work spanned the clinical, operational and financial:

### CLINICAL

- Pairing behavioral health with primary care results in higher quality care, including positive clinical outcomes, high client satisfaction and improved provider satisfaction
- Pairing behavioral health care with primary care improves access to treatment

### BEHAVIORAL HEALTH-PRIMARY CARE-SUBSTANCE USE INTEGRATION CORE ELEMENTS

Core Elements	Sample Best Practices			
	CLINICAL	OPERATIONAL/ ADMINISTRATIVE	FINANCIAL	OVERSIGHT
<b>1 Care Management</b>	Team-based care	Co-location of MH/SU and Primary Care, including “virtual”	Same day visit reimbursement	Locally accountable entity to oversee integration
<b>2 Data Management and Information Exchange</b>	Registry for outcomes tracking and care planning	Information technology/electronic data systems to facilitate information sharing outcomes	Tracking costs and expenditures	Assignment of responsibility and MOUs
<b>3 Engagement of Consumers</b>	Consumer participation in care plan development	Use of peers/promotors	Mechanism for paying for support services linking consumers with needed resources	Consumer participation in care plan development
<b>4 Clear Designation of Person-Centered Health care Home</b>	Bi-directionality	“Warm” hand-off	Clear assignment of responsibility for follow up assessments	Alignment of incentives to support treatment with the preferred choice of provider of the consumer*
<b>5 Performance Measures</b>	Standardized clinical measures across all three disciplines and feedback mechanisms	Process measures	Financial incentives for meeting process measures	Administrative and system change benchmarks to promote alignment



- Routine communications, consultation and coordination between medical and behavioral health providers are critically important
- Universal screening can improve the ability to identify behavioral health needs of the population
- Integration requires a shared philosophy of patient care and collaborative team approach
- Primary care provides needed access to psychiatric consultation
- Medical providers must genuinely believe that providing behavioral health services is in the best interest of the patient, enhances the quality of care and improves provider and clinic productivity
- Behavioral health providers need to know how to adapt to the primary care setting and be comfortable providing brief, solution-focused therapy, be flexible dealing with the physical acuity of the population and the clinic environment where interruptions are the norm

#### OPERATIONAL

- Recognizing there is no one-size-fits all solution, showing practitioners how to customize integration solutions for their delivery system and population will enhance success
- Close physical proximity or co-location and a “warm handoff” facilitate integration
- Offering practitioner toolkits and learning collaboratives can ease customization and implementation of best practices
- Information sharing through medical records and consultations requires support structures
- Administrators and management need to understand and promote the value of integrated behavioral health
- Integration requires an information technology infrastructure that tracks behavioral health data and clinical outcomes
- Patient educational materials and strategies can improve outcomes by extending care beyond the presence of the person providing therapy

#### FINANCIAL

- Integration requires financial reimbursement that aligns with core clinical components of a “warm handoff” – e.g., same day visit reimbursement – care management and crisis intervention
- Meaningful cost offsets can be achieved by treating persons with mild and moderate behavioral health disorders in primary care

**“ WE CAN’T HAVE A HEALTHY AMERICA WITHOUT HAVING GOOD BEHAVIORAL HEALTH.”**

*– Pamela Hyde, Administrator of the SAMHSA*

## Implications and Next Steps

### PRACTITIONERS

Practitioners, whether they have or have not begun the process, can look to a variety of models and resources to support and sustain efforts to integrate behavioral health and primary care. Both primary care and behavioral providers will need to change their modes of practice as person-centered medical homes, care management, and other care coordination efforts become the norm. IBHP has a series of webinars and a comprehensive toolkit available online at [www.ibhp.org](http://www.ibhp.org). In addition, practitioners may want to participate in mentoring or learning circles, which can also be accessed at the IBHP site.

### POLICY MAKERS

Policy makers can build on recent policy developments, such as passage of the Affordable Care Act and federal parity laws, to rework financing structures and incentives. This is a unique opportunity to address policies that hamper appropriate treatment, create inefficiencies and pose barriers to critical components of integration, such as team based care and “warm” hand-offs. There are also important workforce issues to be addressed. There is an inadequate behavioral health workforce, particularly in light of passage of health reform that will result in more people accessing health insurance coverage, increasing demand for services. Training curricula and programs must change to promote integration as the standard of practice.

### FUNDERS

Funders can promote integration through a variety of mechanisms. Stand-alone multi-faceted initiatives, like IBHP, can be replicated to build the field. Funders can also seek to promote integrated behavioral health as part of broader health delivery system reforms underway as part of the Affordable Care Act. For example, funders can partner with health systems to ensure behavioral health is part of the development of Person-Centered Medical Homes. By providing support for peer learnings, information technology structures, education/communication campaigns, convenings, toolkits, evaluations and case studies, funders can leverage resources to advance integrated behavioral health. More information is available at [www.ibhp.org](http://www.ibhp.org).

1. Linkins K, Brya J. Integrated Behavioral Health Project Evaluation: An Assessment of the Field and IBHP's Contributions. February 2010. [www.ibhp.org/uploads/file/IBHP\\_Final\\_Report\\_Field\\_Assessment.pdf](http://www.ibhp.org/uploads/file/IBHP_Final_Report_Field_Assessment.pdf).  
2. Mauer B, Jarvis D, MCPPP Healthcare Consulting. "The Business Case for Integrated Care: Mental Health, Substance Use and Primary Care Services." June 2010.  
3. Hyde, P. [www.youtube.com/user/USGOVHHS?feature=mhum#p/a/u/0/plbTLRXNk8](http://www.youtube.com/user/USGOVHHS?feature=mhum#p/a/u/0/plbTLRXNk8). Retrieved 9-21-10  
4. Soni, Anita. "The Five Most Costly Conditions, 1996 and 2006." Agency for Health Care Research and Quality. Retrieved September 20, 2010. [www.meps.ahrq.gov/mepsweb/data\\_files/publications/st248/stat248.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf).  
5. Rainwater, M. "Integrated Primary Care & Behavioral Health Programs" California Mental Health Planning Council Presentation. June 18, 2009. [www.ibhp.org/index.php?section=news&subsection=show\\_news\\_details&news\\_id=70](http://www.ibhp.org/index.php?section=news&subsection=show_news_details&news_id=70).  
6. "California Primary Care, Mental Health and Substance Use Services Integration Policy Initiative" Volume 1. (2009). Retrieved from [www.ibhp.org/uploads/file/IPI\\_report\\_Final.pdf](http://www.ibhp.org/uploads/file/IPI_report_Final.pdf).