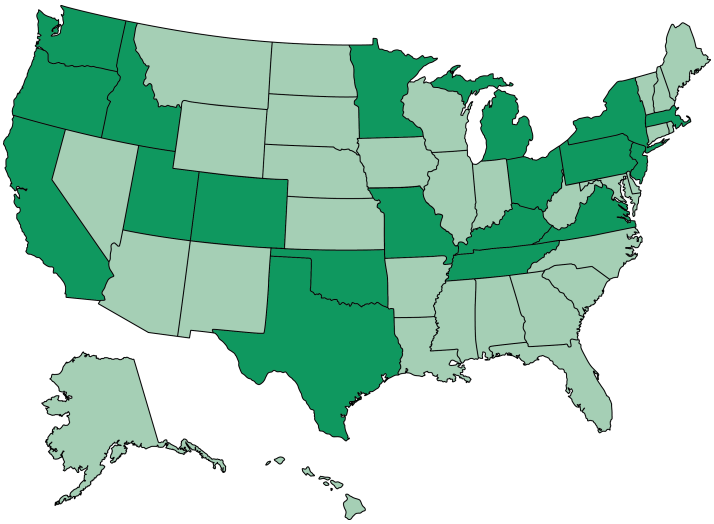
Local Examples: Innovations in Behavioral Health

By Jacqueline Garry Lampert

All too often, health care professionals treat patients only for their physical conditions and not accompanying mental conditions. But, patients with behavioral health issues (which include mental health and substance use conditions) often return to the doctor again and again with similar physical problems related to the untreated behavioral condition—driving up health care costs. For example, one-fifth of patients who have just had a heart attack suffer from depression. When this depression is not treated, the chances of the patient dying from a future heart attack can triple. Untreated depression prevents patients from properly managing other chronic conditions—and often worsens their physical symptoms.

What if patients had access to quality, effective behavioral health care located at the same site as their existing primary care provider? Integrated care for behavioral health in primary care settings, particularly at the same location, can help increase patient screening and treatment, leading to high quality care and better patient health outcomes.



For example:

Nationwide

Depression in Primary Care Program, Aetna

Aetna's Depression in Primary Care Program aims to overcome the stigma surrounding depression by supporting primary care physicians, with whom patients may feel most comfortable talking, to screen patient for depression and monitoring treatment progress. The program aims to address the substantial challenges primary care physicians face in diagnosing and monitoring patients with depression, including lack of time, lack of evaluation and screening tools, and a lack of general support. The Program offers primary care physicians a screening tool, reimbursement for

depression screening and follow-up monitoring, a patient health questionnaire and reimbursement for utilizing the questionnaire. Aetna case managers follow-up with patients and re-administer the questionnaire after treatment begins, providing copies to the primary care physician. Aetna implemented the Depression in Primary Care Program after a study of case management for a small subset of Aetna enrollees with high risk of both medical care and depression found savings of $136-$201 per member per month.

Behavioral Health Optimization Program, U.S. Air Force

Several U.S. Air Force bases offer the Behavioral Health Optimization Program through their primary care clinics. The program started by training behavioral health clinicians in a primary care behavioral health model. At participating primary care clinics, these specially-trained behavioral health providers deliver brief, behaviorally-focused interventions, generally limited to no more than four sessions and focused on education, self-management, and home-based strategies. The program aims to improve the quality of behavioral health care by improving access, identifying behavioral health care needs earlier, matching interventions to the patient's need, and improving collaboration among patients and providers. For some service members, an added bonus is that these visits with a behavioral health specialist are considered primary care, not mental health, and thus do not involve creation of a "mental health record." Services can address a range of problems but are not appropriate for individuals in acute crisis or those who need intensive services.

Mental Health Treatment in Primary Care, Veterans Administration

One of the guiding principles for VA mental health services is mental health treatment in primary care. VA primary care clinics use patient aligned care teams (PACTs) that include mental health experts to coordinate veterans' health care. The PACT may treat mental health problems through partnerships between primary care providers and mental health clinicians, or may refer veterans requiring more complex or intensive care to a specialized mental health program. Two different care models used by the VA are telephone monitoring by a nurse case manager for individuals with depression and referral when necessary, and a software-based assessment to determine which of three different interventions is appropriate: watchful waiting, treatment by primary care, or referral to specialty care. Combining co-located services with care management is the VA's preferred care model.

California

Golden Valley Health Centers

Golden Valley Health Centers, a federally-qualified health center, provides care at 26 locations in Merced and Stanislaus counties. Golden Valley focuses on providing same-day access to behavioral health services for patients being seen by primary care providers. Golden Valley employs 20 behavioral health clinicians, who are integrated members of the primary care team, as well as three psychiatrists, one addiction specialist, two case managers, and three outreach workers. Most referrals for behavioral health services come from primary care providers, but Golden Valley employs a 'no wrong door' policy, and any provider may make a referral. Consultation services may include an assessment, 1-3 brief consultations, consultative co-management with the primary care physician, and/or brief treatment pathways of 3-15 visits.

Colorado

State Innovation Model Grant

Colorado received a significant grant from the Center for Medicare & Medicaid Innovation in order to pursue a statewide behavioral health initiative. The Colorado State Innovation Model (SIM) is aimed at lowering costs and improving care and health of Colorado residents. According to the Commonwealth Fund, the grant will "support the formation of integrated primary care within the state's Medicaid ACOs with payment incentives based on readiness to accept risk and integration of behavioral and clinical care." The goal of the program is to have 80% of residents in 2019 with access to integrated care for behavioral health and primary care in primary care settings. The estimated savings from this project reaches approximately $330 million over the course of five years.

Kentucky and Ohio

Mercy Health System

The Mercy Health system, located in Ohio and Kentucky, has recently started a new pilot program at its primary care offices to screen all adult patients for depression. This effort is in response to the evidence that treating depression in conjunction with other diseases can increase medication adherence, rehabilitation efforts, and lifestyle change. Mercy screens patients with two simple questions and then refers them to one of the embedded behavioral health specialists on site. Patients receive eight brief, focused visits with a behavioral health specialist.

Massachusetts

Massachusetts Child Psychiatry Access Project

The Massachusetts Child Psychiatry Access Project (MCPAP) helps pediatric primary care practices provide comprehensive medical home services through a system of regional children's behavioral health consultation teams. Funding from the Massachusetts Department of Mental Health makes MCPAP services free to primary care providers who choose to enroll in services. MCPAP works to empower pediatricians to provide some behavioral health care within primary care practices, including universal behavioral health screening in the context of well-child care, diagnosing, assessing, and treating the most common psychiatric conditions, such as ADHD and mild depression, familiarity with behavioral health resources for effective referrals, and coordinating care for patients receiving behavioral health care elsewhere. MCPAP offers primary care providers consultation, care coordination, and training and education services. MCPAP recently launched MCPAP for Moms to assist providers serving pregnant and postpartum women and their children in effectively preventing, identifying, and managing depression.

Michigan

Washtenaw Community Health Organization

The Washtenaw Community Health Organization provides integrated health services for individuals with development disabilities and serious mental illness. The Washtenaw Community Health Organization integrated health care model provides physical and mental health in one location, with providers working together as a team. Mental health providers from the community mental health center provide treatment at primary care clinics, and nurse practitioners visit community health centers to provide primary care and care coordination. A partnership with the county public health system and the University of Michigan allows for pooling of funds and sharing of risk.

Minnesota

Depression Improvement Across Minnesota—Offering a New Direction (DIAMOND)

A partnership of medical groups, health plans, employer groups, and the Department of Health Services in Minnesota, funded in part by the Institute for Clinical Systems Improvement, the DIAMOND program uses a model developed by the University of Washington called IMPACT (Improving Mood: Providing Access to Collaborative Treatment). The model was implemented at

more than 75 primary care clinics and relies upon a care manager and consulting psychiatrist to support the primary care provider and utilizes screening for depressions, a patient registry, treatment, and relapse prevention. This collaboration has improved patient outcomes tremendously when compared to patients receiving standard uncoordinated care. The project has successfully experimented with case rate payments with Minnesota health plans providing a per-member per-month payment for a single billing code that includes services provided by both the care manager and consulting psychiatrist.

Missouri

Medicaid Health Homes

Missouri's Medicaid program utilizes a state plan amendment to offer a health home program for beneficiaries with behavioral health conditions. Under this program, community mental health centers that are certified by the state may serve as designated health home providers, offering all health home services in addition to behavioral health care. To be certified, community mental health centers must meet substantial federal and state health home requirements, including active use of the state's electronic health record, recognition as a patient centered medical home by the National Committee for Quality Assurance, and improvement on specified clinical quality indicators. Health homes receive a per member per month fee to provide health home services, including a health home director, nurse care managers, contracts with primary care providers for consultation and treatment, and support staff. Nearly 19,000 beneficiaries are enrolled in community mental health center health homes and early results found that beneficiaries with one or more hospitalizations fell by 27% between 2011 and 2012. Adults who were continuously enrolled in the program since its beginning demonstrated improvement in diabetes management as well as blood pressure and cholesterol levels.

New Jersey

Certificate Program in Integrated Primary Care, Fairleigh Dickinson University

Fairleigh Dickinson, the largest private university in New Jersey, offers a Certificate Program in Integrated Primary Care designed for primary care and mental health care professionals, including physicians, psychologists, nurses, social workers, counselors, and others. The program is completely available online, allowing participants to schedule participation when it works for them. The program includes five units and requires 20 weeks to complete, with participants awarded 80 credits of continuing education or continuing medical education upon completion. The certificate program provides participants with the training necessary to understand and apply the principles of

integrated care, build and maintain integrated care programs, and more.

New York

The Institute for Family Health

The Institute for Family Health locates mental health providers in each of its 19 federally-qualified health centers, which are recognized by the National Committee for Quality Assurance as a Level 3 patient-centered medical home. The Institute began using the IMPACT model of care (Improving Mood, Promoting Access to Collaborative Treatment) in 2003 to screen for and treat depression within its primary care practices and within primary care, in just the past three years, has screened more than 180,000 patients for depression. More than 50% of patients with a positive screening were transitioned into mental health treatment at the Institute. The Institute also partners with New York State agencies and the University of Washington to implement the New York State Collaborative Care Initiative. As part of the state's medical home demonstration, the Institute provides technical assistance to more than 25 hospitals and health centers to assist them in adopting the IMPACT model of care for depression, increase screening, diagnosis, and treatment of depression within primary care, and generally improve the coordination, continuity, and quality of care through integration.

Ohio

Community Support Services

Community Support Services provides comprehensive behavioral health services for individuals with severe, persistent mental illness in Akron and the surrounding region. In 2008, Community Support Services employed a model some refer to as reverse co-location–rather than integrating mental health care into primary care, reverse co-location brings primary care to individuals in treatment for severe and persistent mental illness. The Margaret Clark Morgan Integrated Primary Care Clinic provides a full range of primary care and disease management services, including podiatry and dentistry, in coordination with mental health treatment. One physician and three advanced practice nurses staff the clinic, which hosts the county public health department's dental van once per month and provides podiatry services twice per month. This integrated approach to care has helped patients increase diabetes control and lose weight, among other positive outcomes.

Oklahoma

Family and Children's Services

A partnership between Family & Children's Services, a community mental health center in Tulsa, Oklahoma, and Morton Comprehensive Health Services, a federally qualified health center also in Tulsa, created a unique model for delivering comprehensive primary and behavioral health care services. Together, these organizations have created a comprehensive health home for the underserved mentally ill, with services provided onsite at Family & Children's Services that combine the mental health and substance use disorders treatment available through Family & Children's Services with primary care services from Morton's patient-centered medical home.

Oregon

Native American Rehabilitation Association of the Northwest

The Native American Rehabilitation Association of the Northwest provides physical and mental health services and substance abuse treatment for American Indians, Alaska Natives, and other populations in Portland. Its Totem Lodge program offers integrated services including on-site primary care and mental health providers, case managers, care coordinators, certified addiction counselors and more. The Totem Lodge model and emphasis on integrated care is replicated at all other care sites, which all offer physical health/wellness, mental health, and substance abuse services in a culturally appropriation way.

Pennsylvania

Wellness Recovery Teams

A two-year pilot program in southeastern Pennsylvania utilized a team-based navigator model of care for adults enrolled in Medicaid and who have severe mental illness and at least one chronic medical condition. A navigator assists Medicaid beneficiaries in finding their way through the health care system. The team also includes a registered nurse with behavioral health training and experience and a licensed behavioral health professional. The team develops relationships with everyone involved in the beneficiary's care to ensure consistent care plans and coordinated care, and also work with clients on self-advocacy and self-management skills. All beneficiaries who did not have a primary care physician were connected with one and the vast majority were also connected with specialty care. During the first six months of the pilot program, emergency room visits for medical care dropped by 11%, while medical and psychiatric hospital admissions fell by

56% and 43%, respectively, compared to the previous six months.

Philadelphia Integrated Care Network

The Philadelphia Integrated Care Network is a network of federally-qualified health centers coordinated by the Health Federation of Philadelphia that are integrating behavioral health in primary care. Some of the core elements of the model include population-based care with a behavioral health consultant embedded within a primary care practice for on-demand consultations. The behavioral health consultant conducts consultations to assist primary care providers and does not develop their own patient panel. The consultant and primary care provider communicate regularly regarding treatment plans and care management. Behavioral health interventions focus on improving the patient's quality of life and problem-solving skills. The integrated care initiative now operates in more than 25 sites and includes nearly 40 behavioral health consultants.

Tennessee

Cherokee Health Systems

Cherokee Health Systems designs its care model around a philosophy of care which states, "the best approach to wellness involves treating both the body and the mind." Both a federally qualified health center and a community mental health center, Cherokee Health Systems is a national leader in the complete integration of behavioral and physical health care. In fact, Cherokee Health Systems staff provide technical assistance and training for clinicians and administrators seeking to replicate their approach elsewhere. Integrated care is provided at 45 clinic sites in 14 Tennessee counties, and staff conduct behavioral health outreach at many other sites, such as primary care clinics, schools, and Head Start programs.

TennCare

Tennessee has a history of innovation within its Medicaid program, including the 1994 launch of TennCare, a waiver program that moved nearly all of the state's Medicaid enrollees into a managed care model. At the time of its launch, most TennCare benefits were delivered by managed care organizations under a capitated, full-risk payment arrangement. One notable exception was behavioral health benefits, which were carved out of the managed care model; these benefits were provided by behavioral health organizations under separate contracts with TennCare. A laudable goal of the carve-out was to provide care for adults with serious and persistent mental illness and children with serious emotional disturbance. However, carving out these behavioral health services is in direct conflict with and a barrier to the provision of integrated, coordinated care. TennCare

beneficiaries were forced to navigate two separate systems, including separate provider networks, benefits, cost-sharing structures, and customer service systems, for their medical and behavioral health needs. Health plans were hamstrung in their efforts to coordinate care because no one plan had a complete picture of each beneficiary. In 2007, TennCare began integrating the provision of medical and behavioral health services in a phased-in manner, and the process was completed in 2009. All services are now provided for each beneficiary by one managed care organization, using a capitated, full-risk payment, and providers work to ensure behavioral and medical health services are provided in a coordinated and cost-effective manner. Amerigroup, one of the managed care organizations providing TennCare benefits, reports greatly improved access to care and appropriate utilization of services by TennCare beneficiaries, as well as improved quality. In the state's middle region, managed care organizations performed 20 percentage points above the national average for the management of acute phase antidepressant treatment and 10 percentage points above the national average for 7- and 30-day follow-up after hospitalization for a behavioral health disorder.

Texas

Lone Star Circle of Care

A federally qualified community health center in central Texas, Lone Star Circle of Care uses what it calls a person-centered, behaviorally enhanced health home model, offering primary, integrated mental health, women's health, and dental care, as well as low-cost medication. Integrated behavioral health care is available to patients of all ages and medical and mental health care providers collaborate to address the complete picture of patient needs. In many locations, mental health professionals are co-located within pediatric primary care practices. In 2014, the National Committee for Quality Assurance renewed Lone Star Circle of Care's status as a Level 3 Patient-Centered Medical Home.

Utah and Idaho

Intermountain Healthcare

Intermountain Healthcare uses a team-based approach to integrating mental health care in the primary care setting. Many patients at Intermountain's primary care clinics have multiple conditions that are exacerbated by mental health issues. But a referral to a mental health specialist could take weeks, and the primary care physicians wasn't also informed of the specialist's treatment plan. First, Intermountain provided primary care physicians and support staff with training, empowering them to identify and treat more common mental health conditions, including mild to moderate depression. Intermountain found that about two-thirds of behavioral health

issues identified in primary care can be managed by the primary care physician. Then, Intermountain located a variety of mental health professionals at primary care clinics and worked to truly integrate mental health providers into the primary care team. Providers include psychiatrists, psychologists, psychiatric advanced practice nurses, RN care managers, social workers, and peer mentors. Mental health professionals assess patients and consult with the primary care physician on a treatment plan, and may serve as a "bridge" to help stabilize patients as they wait for a referral to establish long-term mental health care. Patients with depression who were treated in integrated clinics were 54% less likely to visit the emergency room and experienced a cost growth rate 27% lower than patients treated in traditional primary care clinics.

Virginia

Richmond Behavioral Health Authority

Richmond Behavioral Health Authority is a community behavioral health center the received a 4-year, $1.6 million grant from the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integrate Program. This program supports the coordination and integration of primary care services into publicly funded, community-based behavioral health settings. Using these funds, Richmond Behavioral Health Authority developed the Richmond Integrated Community Health (RICH) Recovery Initiative. By expanding on-site primary care and increasing efforts to promote wellness through integrated care, the RICH Recovery Initiative aims to reduce emergency room use and hospital admissions and improve the overall health of its medically underserved population. Primary care is now available 40 hours per week and offers same day appointments for patients with urgent health care needs.

Washington

IMPACT: Improving Mood – Promoting Access to Collaborative Treatment

Designed by researchers and staff at the Advancing Integrated Mental Health Solutions Center at the University of Washington, a substantial body of evidence exists to support the IMPACT model of care (Improving Mood – Promoting Access to Collaborative Treatment). The model is based on five core principles: patient-centered team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care. Now called Collaborative Care, more than 80 randomized controlled trials have found this model to be more effective than usual care, particularly for depression, but also for other conditions including anxiety, PTSD, and co-morbid conditions such as heart disease, diabetes, and cancer. One study, which followed Collaborative Care patients for eight years after the conclusion of treatment, found these patients

were significantly less likely to experience a serious or fatal cardiovascular event than patients who received usual depression treatment. Additional research has found that every dollar spent on Collaborative Care saves up to $6 in health care costs. The Advancing Integrated Mental Health Solutions Centers offers Collaborative Care training, including a free online course for care managers. Washington State's Mental Health Integration Program uses the Collaborative Care model to integrate mental health screening and treatment into safety net primary care settings.