CHI SNAC LABS 2014

Food for Thought

Updates from the Safety Net Advisory Committee (SNAC)

Behavioral Health Integration: Examining Practices to Inform Policy

MAY 15, 2014

Behavioral health integration has been shown to improve access to care and accelerate the Triple Aim goals of improved health, a better experience of care and reduced costs. It is a key component of Colorado's vision for a healthier state.

The Colorado Health Institute is studying integration efforts across the state to identify components of successful implementation and inform both public policy and private market decisions.

Participants in the Colorado Health Institute's Safety Net Advisory Committee (SNAC) Learning Lab on May 15, 2014, discussed lessons that have been learned about behavioral health integration as well as gaps in information. Representatives of 20 organizations, including mental health advocacy groups, safety net providers, consumer groups, academic institutions and state government, attended the meeting.

This report includes background information provided by the Colorado Health Institute and a summary of the SNAC Lab discussion.

Primary Themes

- Behavioral health integration is rapidly evolving.
- A continuum of approaches serve different populations.
- Clinic characteristics matter, the right workforce is key, sustainable funding is elusive and findings from ongoing evaluations may not be broadly applicable.
- Evaluation challenges include how to measure necessary leadership and culture change and how to better understand integration from the patient perspective.

Defining Behavioral Health Integration

From the Lexicon for Behavioral Health and Primary Care Integration: 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. This care may address mental health, 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.

Background: Behavioral Health Integration, Examples and Lessons Learned

A good deal of behavioral health care is provided in a primary care setting. Still, the main role of a primary care clinician is to treat physical problems. He or she may not have adequate training, time or resources to address substance abuse, mental health issues or behaviors that have a negative impact on a patient's well-being. Conversely, a practitioner in a specialty mental health setting may not spot a patient's medical needs.

Such gaps can be addressed through integration. Research suggests that integrating behavioral and medical health can benefit both the patient and the bottom line. There are up-front costs, but a practice with the resources to care for the body and the mind can help the whole person, potentially resulting in better health outcomes and lower health care costs.

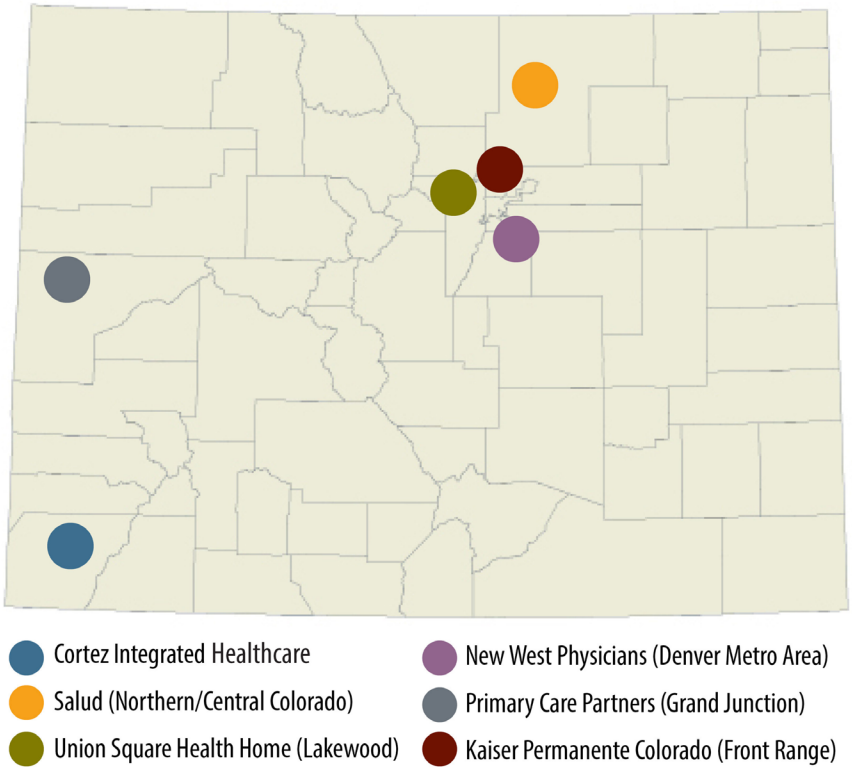
From the Field: Examples of Implementation

While the case for integration is strong, implementation is challenging. It can be as simple as a primary care doctor communicating regularly with a behavioral specialist about a patient they are both seeing. Practitioners may set up shop in the same building, facilitating communication and improving the patient experience.

Full integration happens when a primary care clinician and a behavioral health expert work as a team and share resources. What approach a particular practice adopts depends on several factors, including the needs of the population it serves, the history and culture of the organization and the resources that are available.

The Colorado Health Institute has studied various approaches toward increased integration in Colorado. We focused on six clinics with a variety of business models serving different populations in diverse communities. The goal is to understand how implementation varies, how integration is impacted by policy, and more.

Examples of Integration



Safety Net Examples

- Cortez Integrated Healthcare is part of Axis Health System, which operates community mental health, school-based health and community health centers across southwest Colorado. The Cortez clinic opened in January 2012 and is designed from the ground up for integrated care. Primary care and behavioral health providers work in tandem in shared exam rooms, supported by new tools for screening and sharing health information with each other and with patients.
- Salud Family Health Centers, a community health center with nine clinics across north-central Colorado, has been providing integrated care for many years. At least one behavioral health practitioner is in each primary care clinic, providing screening for new and high-risk patients and ongoing care as needed.
- Union Square Health Home was launched in 2013 in a new Lakewood clinic. The health home serves people with serious mental illness and has a strong emphasis on care coordination. Enrollees in the program receive both their behavioral health care and medical care at the clinic. The Union Square Health Home is a partnership between Jefferson Center for Mental Health (a community mental health center), Metro Community Provider Network (a community health center), and Arapahoe House (a substance abuse treatment provider).

Commercial Market Examples

- New West Physicians is a primary care practice with 16 locations across the Denver Metro area. It collaborates with therapists to help patients access behavioral health care and ensures it is coordinated with their medical care.
- Primary Care Partners has three locations in the Grand Junction area. It is participating in a variety of payment reform pilot projects that support integration of behavioral health. Behavioral health providers in the primary care clinics are available for consultation, diagnosis and to refer patients to needed services.

- Kaiser Permanente Colorado is a health care system with 32 medical offices along the Front Range. Kaiser is building on its integrated medical record and funding model by integrating behavioral health providers into primary care clinics to improve communication and promote patient acceptance of behavioral health services.

Lessons Learned

In examining the experience of these clinics, four lessons emerged:

Lesson 1: Clinic characteristics matter. Safety net providers are innovators and leaders in behavioral health integration. These clinics tend to serve patients with more acute needs and provide a broader scope of services than most private practices. Their nonprofit status makes some grants for integration more available.

Lesson 2: Workforce is key. New kinds of providers – or providers practicing in new ways – are the lynchpin to effective integration. But it is often hard to find "the right fit" for a care team. Integration is all about relationships at a variety of levels – between organizations, between providers, and between providers, patients and families.

Lesson 3: The "value proposition" that will sustain a clinic-level business model for behavioral health integration is elusive. Many of these six examples are in the pilot phase and rely on grant funding. New models of payment and a sufficient volume of patients are needed to make these programs sustainable.

Lesson 4: Ongoing evaluations may not be widely applicable. The scope of evaluation conducted by a clinic depends on resources available and the current needs of the program. While some evaluation work might be helpful to similar organizations at a similar point in their integration work, broader generalization may not be useful.

The SNAC Lab Discussion

The SNAC Lab participants generally felt that these four lessons were consistent with their experiences, but they had several additional observations and questions.

The importance of clinic size for successful integration is debatable.

Many felt that the importance of clinic size for successful integration largely depends on the definition of "full integration," and that much good work can result from partnerships between small primary care practices and behavioral health providers. Participants cautioned against discouraging any specific approach.

The patient experience of integration is important – but poorly understood.

Much discussion involved the patient perspective on behavioral health integration and how to evaluate the patient experience. Client feedback surveys are potentially useful, but participants pointed out that patient satisfaction is not the same as patient engagement or improved health.

Participants also considered how comfortable patients are with behavioral health integration. Integration can reduce the stigma of behavioral health by bringing it into the primary care setting. On the other hand, patients in an integrated setting may feel shortchanged if they're not referred to an outside mental health specialist. And while behavioral health often focuses on adults, it is important to include children and families in the conversation. Identifying potential problems early, before they become more severe, is also a priority.

Further information and evaluation are needed.

There was interest in more outcomes data to determine whether behavioral health integration in Colorado is, in fact, improving health. Some thought it was too soon to see results. Tracking process measures will show whether integration is being carried out in way that results in better health. Participants also citied the importance of ensuring access to care "across the board," not just for particular populations. And they discussed how to evaluate leadership and culture change, two elements that are very difficult to measure but are widely considered critical to successful integration.

Conclusion

Behavioral health integration is a rapidly evolving field. Examples of how it is being implemented provide insight into both the challenges and rewards. It is clear that successful implementation requires change at many levels – for organizations, care providers, and patients.

Update: Access to Care Index

The Colorado Health Institute and the Colorado Coalition for the Medically Underserved (CCMU) are collaborating to create an Access to Care Index, a synthesis of the best data available. This Index will build on existing resources, adding value by looking across various domains and data sources to get a grasp on whether Coloradans have access to the care they need and to monitor change over time.

Guiding principles for this project include monitoring access over the long term, incorporating quantitative and qualitative data components, vetting the approach with stakeholders, recognizing differences in urban and rural areas, and prioritizing areas of focus – both by geography and demographic characteristics. The index will be modeled on a framework developed by the Urban Institute using four domains: community characteristics, insurance coverage, potential access to care, and realized access to care.

SNAC Lab participants offered some suggestions to guide this work. For example, they recommended focusing on barriers that could be removed to improve access to care. The importance of including social determinants of health and geographic characteristics also were emphasized.

Organizations Represented at the May 15, 2014, SNAC Lab

- Advancing Care Together
- Colorado Association for School-Based Health Care
- Colorado Behavioral Health Care Council
- Colorado Coalition for the Medically Underserved
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Health Foundation
- Colorado HealthOP
- Colorado Hospital Association
- Community Care of Central Colorado
- Colorado Department of Health Care Policy and Financing
- Colorado Department of Public Health and Environment
- Jefferson Center for Mental Health
- Kaiser Permanente Colorado
- Mental Health America, Colorado
- Oral Health Colorado
- Quality Health Network
- Rocky Mountain Health Plans
- Rose Community Foundation
- Salud Family Health Centers
- SET Clinic
- Telligen
- University of Colorado School of Medicine

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