

Phyllis Floyd

integrating physical and behavioral health a major step toward population health management

Improved care coordination for patients requiring both physical and mental health services could save the U.S. healthcare system \$26 billion annually while improving quality, outcomes, and patient lifestyle.

AT A GLANCE

Healthcare provider organizations have a choice of five basic approaches to integrating behavioral health services with primary care services, on a continuum from minimally integrated to fully integrated:

- > Cultivation of improved communication and collaboration between the two disciplines
- > Establishment of primary care as the primary behavioral health caregiver
- > Co-location of primary care and behavioral health services
- > Integration of behavioral health with primary care only for chronic disease management
- > Total integration of primary care and behavioral health

Behavioral health is a critical and often-overlooked component of a successful population health management program—a topic frequently discussed but rarely addressed comprehensively. Integration of behavioral health and primary care services can both enhance compliance with preventive care, thereby improving the effectiveness of chronic disease treatment, and help engage patients in self-management to improve lifestyle behaviors that contribute to these chronic conditions. Integration of the two disciplines also can decrease expensive and frequently unnecessary emergency department (ED) visits and inpatient admissions, particularly for patients with more severe mental health conditions, who tend to have a high degree of physical health comorbidities. In short, the clear economic and patient care benefits that can be gained from integrating physical and behavioral health services logically suggest that such a strategy should be a clinical and business priority for any organization making the transition from fee for service to population health management.

Cost Savings Potential: The Elephant in the Room

Physical-behavioral health integration has enormous—and frequently overlooked—potential for producing cost savings. Consider the following factors that can contribute to high costs for patients with behavioral health conditions:

- > Patients who have a chronic disease have a three to four times higher frequency of behavioral health comorbidities, which if left untreated lead

to functional impairments, poor compliance, and increased costs.^a

- > Patients with a chronic disease and behavioral health comorbidity cost as much as 50 percent more than those without the behavioral health condition.^b
- > Patients who are depressed are three times more likely to be noncompliant with a treatment plan and to have a higher risk of physical illness.^c
- > Primary care physicians prescribe 67 percent of the psychotropic medications and 80 percent of the antidepressants in the United States even though primary care has been shown to deliver suboptimal behavioral health care, with inadequate follow-up and monitoring; meanwhile, only one in four patients referred to

specialty mental health make the first appointment.^d

- > From 25 to 50 percent of adults in the United States have a behavioral health condition at some time in their lives, according to various sources.

A report issued by the American Psychiatric Association in April 2014 (cited at footnote b) estimates that \$26 billion to 48 billion could be saved annually through effective integration of medical and behavioral services, representing a 5 to 10 percent decrease in the nation’s overall healthcare costs. The report analyzes the national costs for treating various segments of patients with chronic medical conditions and comorbid mental health disorders and finds that the costs for these patients are two to three times higher than costs for patients with no mental health conditions, *even when those mental*

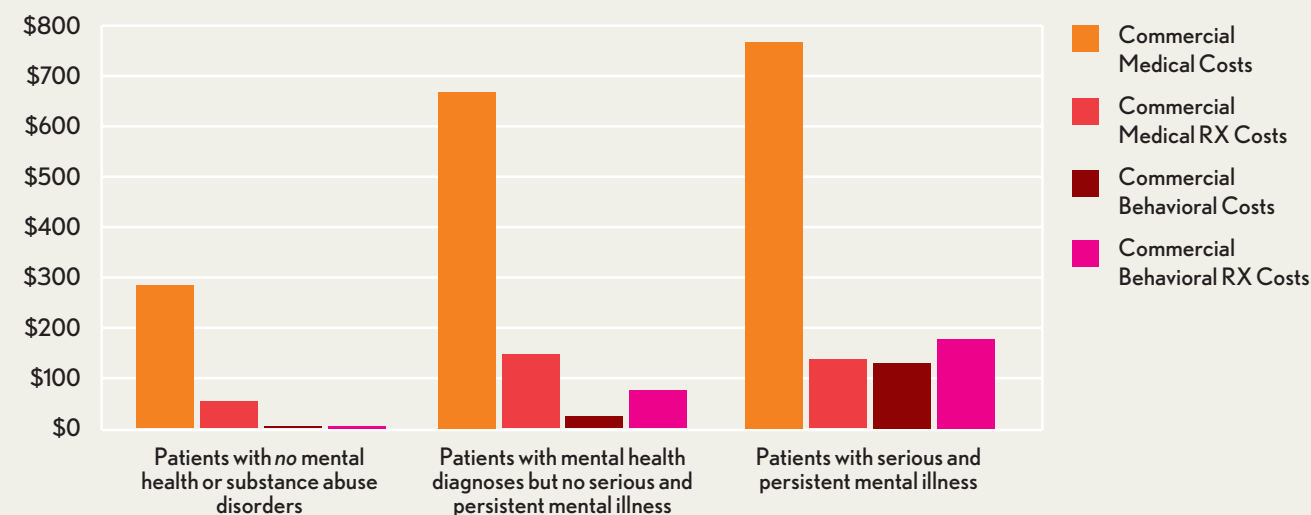
a. Croghan, T.W., and Brown, J.D., “Integrating Mental Health Treatment into the Patient Centered Medical Home,” AHRQ Publication No. 10-0084-EF, prepared for AHRQ by Mathematica Policy Research, June 2010.

b. Melek, S., Norris, D. T., and Paulus, J., “Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry,” prepared for the American Psychiatric Association by Milliman, Inc., April 2014.

c. The Advisory Board Company, “Proactive Behavioral Health Management,” Research and Insights, accessed, Dec. 8, 2015.

d. “Integrating Primary Care and Behavior Health Services: A Compass and a Horizon,” a curriculum for community health centers developed for the Bureau of Primary Health Care’s Managed Care Technical Assistance Program by Mountainview Consulting Group, Inc.

NATIONAL COMMERCIAL SPENDING FOR PATIENTS WITH AND WITHOUT MENTAL HEALTH DISORDERS



Source: Melek, S., Norris, D. T., and Paulus, J., “Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry,” Prepared for the American Psychiatric Association by Milliman, Inc., April 2014.

Benefits of Integrating Mental and Physical Health Care: Case Examples

Published reports have predicted *potential* savings when medical-behavioral integration is fully implemented, with an important example being an April 2014 report performed by Milliman, Inc., for the American Psychiatric Association (APA), which identified the potential for savings of 5 to 10 percent of total healthcare expenditures with effective integration of behavioral and physical care.^a But what has been the *actual* experience of organizations that have accomplished such integration? Several recent studies support the Milliman findings.

The IMPACT study. This study, more broadly referred to as the Improving Mood—Promoting Access to Collaborative Treatment for Late-Life Depression study, focused on elderly patients with co-morbid depression.^b The initial trials of the study, involving about 1,800 seniors receiving treatment in eight healthcare organizations, focused on late-life depression. Older adults who suffer from depression often have high co-morbidities with multiple chronic disease as well as higher costs per patient per year and higher rates of suicide than are seen among older patients who are not suffering from depression. The patients randomized to the IMPACT study group generally were cared for by their primary care physician with the assistance of a depression care manager and a consulting psychiatrist. The psychiatrist served as both a resource for the primary care physician and a referral point for the more recalcitrant patients who were not responding to therapy in the primary care office. The team used a registry to track patients and their follow-up care.

Outcomes of the trial showed a 50 percent or greater improvement in depression at 12 months with the patients in the study versus those with usual care. Among the total healthcare costs, which were tracked for four years, those randomized to a team composed of depression care managers, a primary care

physician, and a psychiatrist were \$70 lower per member per month PMPM than were costs for patients who were not assigned to such a treatment group.

The MDDP program. The Multifaceted Diabetes and Depression Program (MDDP), which targeted depression care primarily for a cohort of low-income patients who were predominantly Hispanic patients, identified medical cost savings of about \$39 per member per month (PMPM) in the first 18 months of implementation of enhanced depression care.^c

The Pathways study. This study, performed at the Group Health Cooperative in the state of Washington, compared results of a randomized controlled trial involving 329 patients with diabetes and comorbid major depression in which one group received aggressive depression treatment (the treatment group) and the other group received usual medical treatment.^d Measuring the effect of the one-year interventions on healthcare costs over five years, the study found that total healthcare costs for those in the treatment group were decreased by \$3,907 per patient, or \$46 PMPM (about 5 percent) compared with costs for the patients who received usual care.

Missouri CMHC program. The state of Missouri has established community mental health center (CMHC) health homes for Medicaid patients with serious and persistent mental illnesses, comorbid mental health and substance use disorders, and certain medical chronic conditions with comorbid mental health disorders.^e The CMHC program is cited in the April 2014 APA report, which notes early results showing an 8.1 percent decrease in overall healthcare costs.

a. Melek, S., Norris, D.T., and Paulus, J., "Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry," Prepared for the American Psychiatric Association by Milliman, Inc., April 2014.

b. Unutzer, J., et al., "Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial," *JAMA*, Dec. 11, 2002.

c. Ell, K., et al., "Collaborative Care Management of Major Depression Among Low-Income, Predominantly Hispanic Subjects with Diabetes," *Diabetes Care*, April 2010.

d. Katon, W.J., et al., "Long-Term Effects on Medical Costs of Improving Depression Outcomes in Patients with Diabetes and Depression," *Diabetes Care*, June 2008.

e. "Missouri: Pioneering Integrated Mental and Medical Health Care in Community Mental Health Centers," Commonwealth Fund, *States in Action*, Jan. 20, 2011. f. "Economic Impact of Integrated Medical-Behavioral Healthcare, Implications for Psychiatry," Milliman American Psychiatric Association Report, April 2014, p. 19.

health conditions were not persistent or severe. It may be surprising to many that the majority of these increased costs are for medical, not psychiatric services. Even among those with serious and persistent mental illness, the costs are primarily from treatment of physical health conditions.

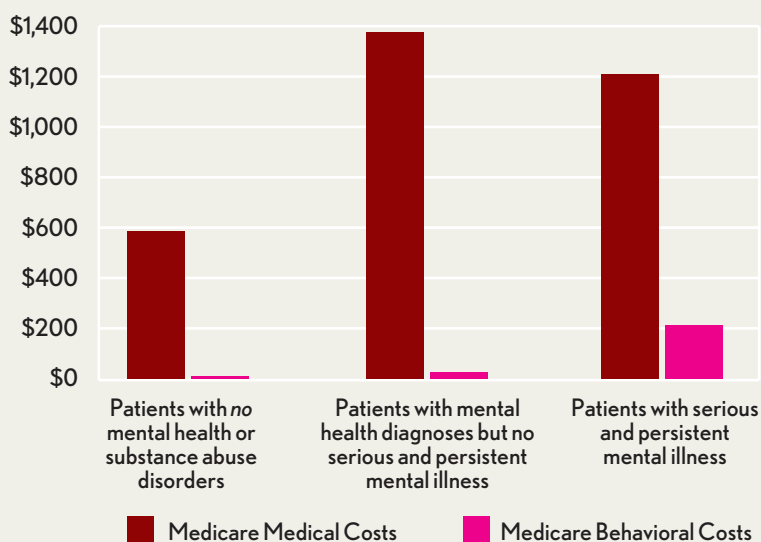
Despite the vast quantity of persuasive data, widespread integration of behavioral health and medical care has been very slow. Among 257 accountable care organizations (ACOs) responding to a recent survey on the extent to which they have clinically, organizationally, and financially integrated behavioral health and primary care, only 14 percent reported being fully integrated.^e This finding is surprising considering that that 80 percent of the ACOs also reported having at least one contract that makes the organization accountable for its patients' behavioral health, and 42 percent reported having behavior health providers in their networks.

Expectations for physical-behavioral integration in patient-centered medical homes (PCMHs) have risen with the 2014 NCQA standards for PCMH certification. PCMHs are now expected to support patients' behavioral health needs, including through collaboration with behavioral health providers. Other potential motivations to integrate are current Medicare ACO contracts and many state Medicaid contracts that include behavioral health services in calculating total cost of care for shared savings and other incentive programs.

There are multiple reasons for this sluggish adoption, including current payment systems that are primarily geared to fee for service and not conducive to integration, the shortage of behavioral health providers interested in an integrated model, and the cultural differences between primary care and behavioral health. Despite these roadblocks, integration of these two specialties

e. Lewis, V.A., Colla, C.H., Tierney, K., Van Citters, A.D., Fischer, E.S., and Meara, E., "Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse with Primary Care," *Health Affairs*, October 2014.

NATIONAL MEDICARE SPENDING FOR PATIENTS WITH AND WITHOUT MENTAL HEALTH DISORDERS



Source: Melek, S., Norris, D. T., and Paulus, J., "Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry," Prepared for the American Psychiatric Association by Milliman, Inc., April 2014.

may be the most important care model change needed to successfully manage population health and risk payment because there is ample data to show solid improvements in patient outcomes, patient engagement, and costs are possible when integration is achieved.

With payers moving more of the financial risk of bundled or total cost of care to providers, and with PCMH requirements focused on behavioral health integration with primary care, there is increasing interest in collaboration between the two specialties to improve patient outcomes and lifestyle and the overall cost of care. To promote such collaboration, organizations must take on the challenges associated with two primary objectives:

- > Integration of mental health with primary care services to provide a more cohesive continuum of care
- > Integration of mental and physical health services for patients with severe mental health conditions

Integrating Behavioral Health with Primary Care to Improve Patient Care Outcomes

Patient compliance with preventive care guidelines and acute or chronic disease treatment plans depends on the extent to which patients are engaged in their care. Ensuring such compliance is the charge of primary care, but patient engagement can be enhanced through some form of integration of behavioral and mental health care into the primary care arena, whether the solution involves a collaboration or a more complete integration of the two disciplines. The full spectrum of behavioral care integration into a primary care practice, from less integrated to more fully integrated, is represented by five possible approaches, or models.

Cultivation of improved communication and collaboration between the two disciplines. This model is not so much care “transformation” as it is an improved relationship between behavioral health and primary care. To establish this type of

relationship, a group of primary care physicians and a group of behavioral health providers (psychiatrists, psychologists, and/or licensed social workers) will meet to discuss and develop communication processes, treatment protocols, and standardized referral guidelines that the two groups will adopt while maintaining separate offices. This model involves the least amount of change from traditional separate primary and behavioral health care but is a good first step for primary care physicians. If possible, it is most helpful to develop a relationship with a behavioral health practice that has all three types of providers—psychiatrists to assist with medication management and counseling; psychologists to provide behavioral management and counseling, especially for patients with chronic disease and the need for behavioral modifications; and licensed social workers who can help patients with the social and life issues that make compliance with treatment plans difficult. (See the sidebar below.)

Behavioral Health Provider Types

Behavioral healthcare services are delivered by a variety of types of providers, with the following being predominant.

Psychiatrist. This practitioner is a medical doctor (MD) who specializes in the diagnosis and treatment of mental illness; a psychiatrist can prescribe medications in addition to providing mental health counseling and other treatment modalities. These physicians are licensed by their state medical boards.

Psychologist. This type of provider is a mental health specialist with a doctoral degree (PhD or PsyD) who works with patients to diagnosis, assess, and manage their mental health issues and improve their overall well-being. These clinicians cannot prescribe medications. They are licensed by various psychology boards or committees of their state.

Licensed clinical social worker. This role represents a subsector of social work that works with patients in a variety of ways to help them deal with issues related to their mental and emotional health. A licensed clinical social worker requires a Master of Social Work degree (MSW). Licensing varies by state.

Mental health counselor. These care providers are mental health specialists who work with patients to treat mental health issues usually with supervision by one of the specialists described above. The role requires a Master of Psychology degree. Licensing varies by state.

The primary incentive for providers to adopt this approach is to achieve improved coordination of care for patients, a consistent resource for psychiatric consultation for primary care physicians, and more appropriate referrals for behavioral health. Implementation challenges include cultural differences, a lack of existing relationships between primary care and behavioral health upon which to build a collaboration, insufficient time to develop protocols when the groups may have different clinical management styles, and the lack of payment for such coordination of care in a fee-for-service world.

Establishment of primary care as the primary behavioral health caregiver. In this model, the primary care provider develops the proficiency in treating behavioral health issues to become a provider of non-complex behavioral health care (leaving care of more complex psychiatric illness to the behavioral health specialists). This proficiency might be obtained through training provided by a collaborating group of behavioral health providers or through more traditional continuing medical education.

This model requires the use of evidence-based behavioral health screening tools (e.g., the use of the Patient Health Questionnaire [PHQ-9] for depression) and algorithms agreed upon by the primary care practitioner and the consulting psychiatrist. The model also can fulfill the behavioral health requirements for PCMH certification.

The model works best if the primary care practitioner has consultative support from a psychiatrist. In the past few years, with the advent of telehealth, it has become possible for psychiatric services to be provided either onsite or remotely. Using telehealth for mental health consultations can significantly increase the availability of a psychiatrist, enabling the specialist to team with multiple primary care practices. Behavioral telehealth may be one of the more effective applications of telehealth services, because both outcomes and patient acceptance for

an encounter using this method have been shown to be the same as with face-to-face visits.^f

The downside of this integration model is that many primary care physicians do not have the time or interest to deliver behavioral health treatment in their practice. The primary care provider also should clearly understand how to code for these visits to optimize the income for time spent treating behavioral health issues and be able to afford ancillary providers trained in mental health (such as an RN mental healthcare manager). A potential pitfall is the surprisingly high likelihood that the primary care physicians will lack any good relationship with a mental health professional on whom they can rely for phone consultations and who is interested in jointly developing care protocols.

Co-location of primary care and behavioral health services. Practitioners can improve the level of coordination by co-locating offices while keeping billing and administrative functions separate. This approach allows patients to witness the collaboration and feel more comfortable with a behavioral health referral, and it mitigates the stigma of a referral to a mental health provider. With this close physical tie, both provider types can more easily collaborate with each other on treatments of individual patients, with team meetings aimed at facilitating a shared treatment plan. This model works best for patients who do not have severe mental health disorders.

This approach, like other integration models, promotes coordination of care between the two service areas and fosters improved patient compliance and experience benefits. Challenges are primarily administrative:

- > Mental health records have more regulatory requirements than physical health records and must be stored separately.
- > Mental health providers have longer appointments and may become overwhelmed with the volume of referral by the primary care practice, making it important for both parties to

f. *Practical Guidelines for Video-Based Online Mental Health Services*, American Telemedicine Association, May 2013.

understand the model of care to be provided in this arrangement.

- > The benefit design for behavioral health often is structured differently, potentially making financial integration difficult.

Integration of behavioral health with primary care only for chronic disease management. This is the most frequently used approach for integrating behavioral health services in a primary care practice. It is especially common in practices that are PCMH-certified and embrace the new behavioral health requirements. In this model, nurse care managers and social workers are the primary behavioral health practitioners, receiving support from psychiatrists and primary care physicians. The model is used to improve the coordination of care and patient self-management of chronic diseases such as diabetes, congestive heart failure, and mild to moderate depression.

This model requires a patient registry or tracking system to be effective. It requires buy-in from both primary care and behavioral health practitioners, who must work together to develop protocols and guidelines for the ancillary staff. The registry also must support both physical and mental health chronic conditions. The model is useful for improving outcomes in patients with chronic disease who tend to be noncompliant without additional support. Some practices also employ a behavioral health practitioner to

enhance patient support by performing group visits and to provide care for patients with more complex or difficult-to-treat chronic diseases.

The main drawback to the model is the expense of the additional behavioral health personnel, especially in a predominantly fee-for-service environment. If the practice adds a behavioral health professional, there is opportunity to bill for services, but the mental health benefit plan may have restrictions that make such billing difficult. With the movement to value-based reimbursement models, there is opportunity to negotiate a chronic disease management fee per member per month (PMPM) for this population that can be used for supporting the salaries of behavioral health providers.

Total integration of primary care and behavioral health. This is the “holy grail” for integration of mental health and primary care services, in which the mental health practitioners are fully part of the primary care practice’s multidisciplinary team, with integration of clinical services, administration, and finances. The primary care and behavioral health practitioners interact frequently, and they typically have an integrated medical record with a single treatment plan for each patient. Almost all mental health needs are met inside this model. Typically both behavioral health and primary care providers are employed, and there is support for this model from a

PRIMARY CARE NEXT STEPS RELATIVE TO THE PAYMENT MODEL	
Payment Model	Summary of Primary Care’s Steps to Behavioral Health Integration
Fee-for-service	<ul style="list-style-type: none"> > Develop a relationship with psychiatrists, psychologists, and licensed social workers in your area who are on the same health plans as your practice. > Analyze data to find prevalent comorbidities. > Evaluate telehealth capabilities for psychiatry consultations.
Fee-for-service plus quality incentives and chronic disease management fees	<ul style="list-style-type: none"> > Negotiate quality incentives related to behavioral health issues (e.g., depression screening) with your payers. > Negotiate a per-member-per-month care management fee for patients with chronic conditions including mental health conditions.
Total cost of care	<ul style="list-style-type: none"> > Contract or employ behavioral health providers in your practice and move to a fully integrated team model. > Potentially use telehealth for some of the mental health consultative needs.

SUMMARY OF THE LEVELS OF POTENTIAL INTEGRATION WITH PRIMARY CARE AND BEHAVIORAL HEALTH

Types of Primary Care-Behavioral Health Integration	Collaboration Continuum				
	Minimal	Basic at a Distance	Basic On-site	Partially Integrated	Fully Integrated
1. Focus on improved collaboration between separate providers	X				
2. Behavioral health care delivered by primary care physicians		X			
3. Co-location of primary care and behavioral health			X		
4. Disease management integration of both services				X	
5. Totally integrated and collaborative system of care					X

financial risk arrangement through payer or direct employer contracts in a clinically integrated network (CIN) or an ACO. This type of team-based multidisciplinary integration has the best outcomes in terms of clinical improvements and cost efficiency.

Next Steps for Primary Care

So how should a CIN, ACO, or medical group leadership team proceed? As noted in the model descriptions above, the financing of these behavioral health integration models is the biggest hurdle to implementation. To obtain this financing, the CIN, ACO, or medical group must move to more value-based payment models with the predominant payers in their areas. This move can start with incentive payments or PMPM management fees, but the ultimate goal should be a total-cost-of-care model that includes behavioral health costs. The value-based payment model should create a strong incentive to develop and maintain a fully integrated primary-care/behavioral-health model of care. Organizations that are still in a fee-for-service environment should focus on three essential steps:

- > Promote improved collaboration between primary care and behavioral health providers in their communities (potentially using telehealth if access to behavioral health is difficult)

- > Educate primary care providers on how they can best deliver basic behavioral health services
- > Implement behavioral health screening techniques as part of the PCMH journey

Specifically, as organizations progress from fee-for-service to the increased risk of a fee-for-value environment, they should use that time to educate primary care physicians on improved behavioral health techniques, analyze claims data to understand the prevalence and costs of medical-behavioral comorbidities, develop relationships with behavioral health providers, explore and develop telehealth capabilities if needed for psychiatric access, and begin the cultural transformation of the practices to appreciate the need for the fully integrated model.

Integrating Physical and Mental Health Treatment for Patients with Severe Mental Health Conditions

Patients with severe depression, bipolar disease, schizophrenia, or addiction disorder have difficulty complying with treatment of concomitant physical conditions when their decision-making power is compromised by their mental health disorder. The primary sites of care for these patients are mental health clinics, substance abuse clinics, intensive day-treatment

facilities, and, in some cases, mental health inpatient facilities. The need for integration of physical and mental healthcare services for patients with severe behavioral health disorders derives in large part from the high incidence of physical medical conditions among these patients (including substance abuse), occurring in about two-thirds of the patient population.

The most common physical conditions to which patients with severe mental health issues are susceptible are diabetes, obesity, coronary artery disease, and hypertension. The best way to integrate physical and mental health care for these patients is to use a “reverse integration” model, in which a primary care provider (usually a nurse practitioner) is integrated into a behavioral health setting. Although not very common, this type of integration has been shown to significantly increase compliance with treatment

plans for chronic medical conditions among patients with severe mental health diagnoses.

Drawbacks of the Reverse Integration Model

Success depends, of course, on there being close communication between the disciplines so that the medical and mental health treatment plans are collaborative and well-coordinated. Like co-location in a primary care setting, the reverse integration model has a drawback in that mental and physical health medical records must be maintained separately. Patients with severe mental health conditions also are less likely than the general population to have health insurance or Medicaid coverage, creating a challenge for funding this model, despite evidence that such coordination of care is associated with reduced emergency department visits, inpatient admissions, and utilization of other high cost services.

HEDIS METRICS RELATED TO SEVERE BEHAVIORAL HEALTH CONDITIONS	
HEDIS Metric	Description
Follow-Up After Hospitalization for Mental Illness	This metric reflects the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a behavioral health provider. The metric considers the percentages of these patients who received a follow-up within 7 days and within 30 days of discharge.
Antidepressant Medication Management	This metric applies to the percentage of patients 18 years of age and older who had a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment through an effective acute phase treatment for at least 84 days or through an effective continuation phase treatment for at least 180 days.
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	This metric looks at the percentage of patients 18–64 years of age with schizophrenia or bipolar disorder who received an antipsychotic medication and had a diabetes screening test during the measurement year.
Diabetes Monitoring for People with Diabetes and Schizophrenia	This metric reflects the percentage of patients 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	This metric looks at the percentage of patients 18–64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	This metric reflects the percentage of patients 19–64 years of age during the measurement year with schizophrenia who received and remained on an antipsychotic medication for at least 80 percent of their treatment period.

BEHAVIORAL HEALTH NEXT STEPS RELATIVE TO PAYMENT MODEL

Reimbursement Model	Summary of Behavioral Health Integration with Primary Care
Fee-for-service	<ul style="list-style-type: none"> • Develop a relationship with a primary care practitioner who is willing to see patients from behavioral health clinics or treatment centers. • Make sure that the primary care practitioner is trained in coding for the complexity of care for these patients.
Fee-for-service +quality incentives	<ul style="list-style-type: none"> • Negotiate quality incentives related to behavioral health issues (e.g., depression follow-up) with payers.
Total cost of care	<ul style="list-style-type: none"> • Employ a primary care practitioner for the mental health practice to promote collaboration between physical care plans and behavioral health care. • Analyze patient costs and identify the high-cost patients, and evaluate other opportunities for providing high-quality, lower-cost care.

Because of the complexity of these patients, however, primary care providers can code a more complex level of service, which can help strengthen the financial model in a fee-for-service environment. In a large integrated system, there is also opportunity to negotiate a value-based contract with a quality incentive or shared savings program. Several HEDIS metrics that are related to the treatment of severe mental health disorders provide a good starting point for an incentive-based contract.

Next Steps for Mental Health Clinics

For accountable care organizations and multispecialty medical groups that are contracted for the total cost of care (including behavioral health), integration of physical and mental healthcare services for patients with severe mental conditions is imperative. Collaborative treatment of these patients’ mental and physical conditions is necessary to improve outcomes under both disciplines and to avoid unnecessary costs of noncompliance among patients who suffer from chronic physical conditions, in particular. The “plan of action” for those accountable for the care of these patients is summarized in the exhibit above.

Key Strategic Considerations

The mind and the body cannot be separated, and neither should the health of either be treated without regard for the health of the other. Treatment for the mind and body should go hand

in hand, preferably being integrated in the same setting, to enhance the patient’s experience and compliance. Various models exist to achieve this integration, and when accompanied by complementary changes in the payment model, clear improvements in outcomes and efficiencies are possible.

As you consider your next move, ask yourself the following:

- > Do our patients have a seamless experience for both their physical and behavioral health needs?
- > Do we consistently meet all of the physical needs of our patients who have complex or severe mental health conditions?
- > Are we satisfied that we have fully integrated our physical and behavioral health services to the point we are achieving the highest-quality and most cost-effective outcomes that are possible?
- > Do we consider our behavioral health integration when we negotiate value-based contracts, including PMPM management fees to finance this additional service?

If you answered “no” to any of these questions, then it is time to get started by including behavioral health integration in your strategic planning. To this end, we offer the following strategic recommendations:

- > Size the behavioral health-physical health integration opportunity for potential savings and clinical outcome improvements.

FEATURE STORY

- > Choose a primary care physician and a behavioral health physician who believe in the concept to co-champion this care model transformation. A likely candidate on the primary care side would be a physician who has embraced the PCMH concept (including behavioral health integration as part of PCMH).
- > Pilot a site that has potential for real impact with one of the described models that best fits the population served and the resources available. This step may require an investment for the costs of the behavioral health providers or additional training of the primary care physicians while you negotiate for value-based incentives with payers or employers.
- > Expand the pilot sites and the level of integration as funds become available through successful value-based contracting efforts.
- > Communicate the value of this model as you expand the concept to be part of your culture and standard of care for your CIN, ACO, or medical group. ■

About the author



Phyllis Floyd, MD,
is senior advisor, BDC Advisors, LLC,
Miami (phyllis.floyd@bdcadvisors.com).