PLANNING STRATEGIES FOR BEHAVIORAL HEALTH: INTEGRATED FROM THE GROUND UP

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ISSUE
As health systems consider what their campuses and networks will look like five to ten years from now, planning for future integration between behavioral and medical health services is an important step that can often be overlooked in planning studies.

DRIVERS
Inadequate reimbursement models, barriers to integration with electronic health record systems, and a shortage of both mental health practitioners and team-based trainings have limited the adoption of fully integrated models of care thus far.

SOLUTIONS
• Examine examples from leading organizations such as Intermountain Healthcare and UnityPoint Health-Trinity that offer different models for behavioral health integration.
• Understand the financial, cultural, operational, and facilities implications associated with integrating behavioral health into medical care.

The statistics are staggering. More than 80% of patients with behavioral health conditions first seek care in medical care settings resulting in 60 to 70% of these patients not receiving care for behavioral health conditions. Furthermore, approximately 26% of adults with medical conditions have cooccurring mental disorders, with medical costs that can reach two to three times the costs of patients without comorbid conditions. Effective integration between medical and behavioral healthcare is estimated to have a potential annual national savings of $26.3-$48.3 billion. However, although integrated behavioral healthcare has seen a dramatic uptick over the last decade, the financial models and structural requirements for effective implementation of integrated solutions are still evolving. This can make it extremely difficult to plan ahead, oftentimes leading to maintaining current levels of segregation of behavioral health services in master and strategic planning activities – steering health organizations away from solutions that truly address overall population health.

This paper examines:
• The existing barriers to effectively integrating behavioral healthcare across the care continuum
• The healthcare organizations that are making significant strides towards full integration of behavioral health services
• The financial, operational, and facility considerations for preparing for increased levels of integration in the future
Understanding the Barriers to Integration

Across North America, there is a significant gap between the number of people with diagnosable behavioral health issues and the number of people who are actually receiving treatment. This gap in care is putting increasing financial and infrastructure pressure on other settings – such as emergency departments, law enforcement, courts, prisons, and other community resources.

Integrating more comprehensive behavioral health services, beyond preliminary screenings, into general healthcare settings is largely seen as a positive step towards improving the somewhat fractured behavioral healthcare systems in North America, with the potential to reduce the national financial burden of comorbid behavioral and medical conditions by 9-16% in the United States.3 It is also understood to be a critical component of an effective population health management strategy and preventative medicine. However, health systems are facing significant challenges.

Financial Viability
Though ACOs and other patient-centered medical home models are increasing the demand for a behavioral health professional within their care teams (FIGURE 1), many payers are still not adequately funding behavioral healthcare services as part of their physical health reimbursement policies. This results in a significantly lower percentage of providers from providing care compared to other specialties.1 Payment models that are non-encounter based and non-volume based will allow a greater level of integration to be achieved.4

Electronic Health Record Adoption
Behavioral health organizations have lagged behind in adoption of electronic health record systems due to lack of resources and incentives, privacy concerns related to federal behavioral health regulations, and a lack of health IT resources.5 This greatly impacts the ability to effectively coordinate care.

Personnel & Training
As of April 2014, there were 3,968 mental health professional shortage areas across the United States – equating to only slightly more than 50% of service areas meeting their need for mental health professionals.6 It would take 2,707 practitioners to remove this designation.4 This indicates a significant need for more federal and state incentive programs for mental health care professionals. Beyond that, in order for integrated behavioral health to be successful, team-based trainings that move beyond simply co-locating behavioral health and medical care professionals to models of true collaboration need to be created and incentivized.4

FIGURE 1 In emerging primary care (top) and specialty care (bottom) models of care, patients are treated by an integrated team that includes mental health professionals.
Case Study #1: Intermountain Healthcare

With 22 hospitals, 130 primary care clinics, and nearly 3,000 affiliated physicians, Intermountain Healthcare (IHC) began to focus on Mental Health Integration (MHI) in the late 1990s when their physicians were feeling overburdened by demand and ill-equipped to meet the needs of patients also exhibiting mental health conditions.

IHC has developed and sustained their MHI program through 3 basic components:

Mental Health Assessment Tool: When a patient arrives to see the primary care physician, the patient completes a baseline evaluation that includes initial history and consultation, family history, a patient health questionnaire (PHQ-C), and a variety of other assessments dependent on age. The care teams follow protocols depending on the extent of the mental health problem: mild, moderate, or severe. The results of the questionnaire are reported centrally to keep all informed and reinforce consistency of practice.

Operational Infrastructure: Mental Health Specialists and nurse care managers are included in the primary care team. The new team members are either designated within one clinic or rotate through multiple clinics, depending on the clinic size and need.

Program Evaluation: IHC leadership frequently evaluates the program to monitor patient outcomes, team effectiveness, and culture from the perspective of the patient and the provider.

The collaborative approach ensures that mental health services are available to all patients regardless of their degree of mental health condition or financial complications. Additionally, it ensures the PCPs feel able to support the volume of patients and levels of patient complexity. All members of the care team have been involved in improving patient care including the patients, their support systems, and the community.

Outcomes

Today, MHI is present at 82 Primary Care Practices, five specialty clinics, and 45 clinics outside of IHC through cross-country partnerships. According to Brenda Reiss-Brennan (2014), the Director of MHI at IHC, IHC has seen some impressive results:

- MHI clinic patients suffering from depression are 54% less likely to require a visit to the emergency department than depressed patients treated in non-MHI clinics.
- Health insurance claims from patients involved with at least one of the MHI clinics decreased by an average of $667 in the year following their diagnosis.
- Patients utilizing MHI clinics are reporting improved overall functioning in their lives - 81% of patients feel hopeful that they can get well and stay well.

Financial Viability

Adding mental health professionals required upfront costs. However, the cost of increased salary is being offset by new billings and improved quality outcomes such as a reduction in unnecessary visits to the emergency department, unnecessary imaging, or other waste. Intermountain still operates under a fee-for-service payment model and due to carve outs for mental health under many health plans, some mental health conditions are not paid for.

Electronic Health Record Adoption

A secure centralized repository allows the whole team to access and update records, communicate with each other and enhance coordination. These systems also allow the health system to monitor outcomes data to ensure patient health is improving and they are providing better care at lower costs. Patients are also able to email their primary physician.

Personnel & Training

Integrating leadership “champions” who have mental health and medical backgrounds provide institutional commitment and accountability for MHI goals. The mental health team may include the PCP and one or more mental health specialist (psychiatrists, psychiatric nurse practitioners, psychologists, social workers and care managers) who need to be able to work seamlessly with each other, other providers, patients, families, and even insurers. The clinic and regional administration are responsible for all training of these different backgrounds to work in primary care together and use standardized tools.

References


Planning for Integration

While these barriers can be challenging to overcome, a review of literature revealed that there are several organizations that have found ways to proceed with behavioral health integration and have started to see many of the promised benefits. Undoubtedly, it is important for all health organizations to begin to consider their options related to integration.

A review of the case studies we identified (two of which are included in this report) combined with the expertise of CannonDesign’s subject matter experts, revealed that there are many things that should be taken into consideration when planning for integration between mental and physical health services and a variety of frameworks that can be considered (FIGURE 2). Ideally, the operational, financial, and facility implications should be carefully considered ahead of any major integration initiatives.

Financial

- Differences in payment models can hinder the success of co-location efforts as they can create financial hardships and stress that insulate behavioral health practitioners from other practitioners.
- It is important to explore more global payment models, such as shared savings, when integrating care services.
- Helping patients navigate multiple health systems and coordinating their care between providers can have a significant impact on outcomes and cost.
- Costs can be mitigated by adding resources slowly to make sure provider hours that have been allocated are filling up.

Cultural

- There may be initial resistance from primary care providers to having behavioral health specialists on staff; it is important that PCPs understand the financial, operational, and clinical outcomes and benefits of collaborative models.
- Prior to major initiatives, a hospital or care system should explore behavioral health integration in-depth with the physician leaders, as physician buy-in is critical.
- Extensive collaboration methods can be necessary to improve understanding and awareness between medical and nonmedical practitioners.
- Local site participants should be involved in implementation efforts to assure buy-in and proper customization to site opportunities and constraints.
- Team collaboration, including the receptionist, the provider’s MA, RN care managers, the mental health practitioners, and the PCP, is critical for success so much of the burden is taken off of the PCP.

<table>
<thead>
<tr>
<th>Integration Framework</th>
<th>Description</th>
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<tr>
<td>AHRQ Framework for Primary Care</td>
<td>This framework is based on the idea that integrated behavioral health care includes a team of primary and behavioral health clinicians that work with patients and families to provide patient-centered care for a defined population, using a systematic and cost-effective approach. (cite link above) The framework follows 10 functional domains, including such items as Clinical Workflow, Patient Identification and Leadership Alignment, which have a specific structure and process that allows for measurement of outcomes.</td>
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<td>IMPACT</td>
<td>IMPACT is an evidence-based integrated care model that focuses on the care of older adults, and has been tested in a variety of settings, from hospitals to HMOs to VA clinics. The model is based in collaborative care, which is one of the five key components that drive the success of this flexible model. The other elements include a Depression Care Manager, a Designated Psychiatrist, Outcome Measurement and Stepped Care. A variation of this model leverages telepsychiatry to support behavioral health treatment when on-site care is unavailable.</td>
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<td>Three-Component Model (TCM) Care</td>
<td>This model focuses on care management, enhanced mental health support and a prepared practice as key components to integrated care. The model can be centralized within the organization or can be localized with services available via phone or other venues. Care management entails patient education, counseling for self-management and communication with other clinicians involved in patient care. Enhanced mental health support is provided by a psychiatrist, who supervises the care manager and supports the PCP. Prepared practice is primarily driven by the psychiatrist, who provides educational resources and information regarding the behavioral health diagnosis and care.</td>
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<td>Co-located Collaborative Care</td>
<td>The primary feature of co-located collaborative care is that the mental health specialists are located within a primary health clinic, and often work in collaboration with the PCP. Another component of this model is the use of triage to indicate the level of care required based on patient need, risk or severity. Success of this model requires personnel training to ensure both mental health and clinical providers are aligned with the expectations and requirements of the model. See Intermountain Healthcare case study for an example of this type of care.</td>
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<td>6P Framework</td>
<td>This framework, supported by the Robert Wood Johnson Foundation, incorporates the perspective of six groups of stakeholders to support the use of evidence-based care for depression, and unlike most other models, incorporates economic considerations and financial incentives to its implementation. The program defines key features for treating depression in primary care, including a leadership team, decision support to enhance evidence-based guideline adherence, delivery system redesign, clinical information systems, patient self management support and community resources.</td>
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FIGURE 2 A variety of frameworks have been developed that can be considered for integrating medical and behavioral health services.
**Operational**

- Partnerships between local behavioral health providers, safety net providers, and larger healthcare systems can be integral to success in integrating physical and behavioral health into the care continuum.
- When advancing new integration initiatives, additional organizational resources are often required for proper education and training.
- Regularly assessing each site of integration is necessary to ensure each site has access to enough resources to fit their patients’ needs.

**Facilities**

**Primary Care**

- Basic integration can be supported simply by using a generic treatment room module. Rooms can then be modified and configured according to the needs of the patient. If the room is used for a behavioral health assessment, furnishings can easily be added to create spaces that are more consultative in nature. Centralized check-in can be used in this model, assuming that basic privacy requirements are met.
- If clinics go as far to offer mental health group therapy services within their primary care facilities, it is important to understand that these services are often provided after hours in evenings (AA, Family Groups, Eating Disorders groups). Therefore, clinic zoning should allow for evening access to group rooms without allowing access to the entire clinic. It is also important to understand that some mental health counseling sessions during regular business hours include families and require larger spaces, and may require space for additional traffic flows.
- Group rooms ([FIGURE 3](#)) should be considered and can be used for other group appointments and meetings (e.g., for diabetes care, etc.). Noise/access to and from these group spaces should not disrupt one-on-one counseling or medical examinations occurring along the path of travel.
- If repetitive counseling/treatment is needed for specialty populations/diagnosis groups (i.e., Eating Disorders, PTSD, Sexual Assault, Domestic Abuse), spaces should allow for some level of segregation. Additionally, special requirements should be considered – for example, smaller private waiting rooms for different age groups, women/families and appropriate furniture selections for the variety of individuals of all sizes, as well as toys/play areas that are age appropriate.

**Emergency Care**

- The provision of “safe” treatment rooms in the Emergency Department creates space for behavioral health stabilization and assessment. When necessary, a sliding metal “garage door” can be lowered to separate the patient from equipment and supplies ([FIGURE 4](#)).
- When inpatient behavioral health services are on-site, consider ways that planning and design can facilitate a safe, efficient transition from the Emergency Department when necessary.
- When volumes require it, a dedicated behavioral healthcare ED or crisis stabilization unit nearby the main ED can help behavioral health patients de-escalate.
**Case Study #2: Robert Young Center for Community Behavioral Health, Rock Island, Illinois**

The Robert Young Center, part of the UnityPoint Health-Trinity, is a community mental health center with a 25-bed adult psychiatric unit, 6-bed child and adolescent unit and a 16-bed chemical dependency unit. Since 2009, the Center has partnered with Community Health Care (CHC), a federally-qualified health center, to create better integration between behavioral and medical healthcare services.

Collaborating with CHC and the Iowa Health Physicians, behavioral health specialists—licensed clinical social worker or licensed clinical professional counselor—are embedded into five primary care locations and provide assessments, treatments and consultations. Beyond primary care, The Robert Young Center is committed to integration of physical and behavioral health services occurring across the entire care continuum including: inpatient child and adult psychiatric units, outpatient behavioral health services, community treatment (including skills training and employment assistance), home- and school-based behavioral services, and telepsychiatry for outlying emergency departments and jails.

**Outcomes**

Over the course of two and a half years, the Robert Young Center had the following positive outcomes:

- 49% reduction in ED visits and 54% percent reduction in psychiatric admissions
- 65% reduction in Medicaid costs
- 137% improvement in quality of life score
- 88% percent reduction in inpatient costs
- Preventative health services rates and chronic disease management ratings are significantly better than state of Illinois and national averages.

![At UnityPoint Health-Trinity in Rock Island, IL a crisis stabilization unit is located adjacent to the ED. Inside the crisis stabilization unit, a “living room” lounge is designed to give patients a safe, inviting environment for deescalation.](image)

**Financial Viability**

In 2010, the Robert Young Center received a three-year Federal Donated Funds Initiative grant to support the development of an integrated system between the Robert Young Center and Community Health Care (CHC). This coordinated care initiative is estimated to have resulted in approximately $8 million in savings. In 2014, CHC was awarded a $250,000 grant that will be used to expand the partnership with Robert Young Center.

**Electronic Health Record Adoption**

UnityPoint Health-Trinity uses Epic to track inpatient and outpatients throughout their system. If a behavioral health patient is treated in their system (from ED to inpatient hospitalization to community clinic referral), they are able to track that patient throughout the continuum of care.

**Personnel & Operations**

Education was provided to all medical and allied health staff from CHC about the relationship between physical and behavioral health problems, trainings and consultations regarding medication management for behavioral health issues, and medical case management for patients with chronic health problems such as diabetes and cardiovascular disease.

**References**


Conclusion

Healthcare organizations are facing any number of financial pressures and are being forced to make hard decisions on where they will continue to invest in the future. The integration of behavioral health into medical care can have significant upfront costs, especially as payment models and technological infrastructure lag behind the thoughtful operational models that have been put forward. However, leading healthcare organizations have demonstrated that if executed effectively, comprehensive integration of behavioral health can have significant benefits for both patients and providers. As we enter an era of healthcare where the success of healthcare providers will largely depend on the effectiveness of their population health strategies, healthcare organizations need to continue to think creatively about how they integrate behavioral healthcare across multiple settings within their systems.

References


Contributors

Tim Rommel, leader of CannonDesign’s Behavioral Health design group, is a recognized expert in the planning and design of psychiatric care facilities, with several dozen highly regarded projects to his credit.

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