Building paths, demolishing walls
The challenge and necessity of integrating behavioral health and primary care

Integrated care involves a whole-person, patient-centered approach that engages patients in the full range of physical, psychological and social aspects of care. That does not describe the status quo: Behavioral and physical health operate in their own silos, to the detriment of patients, the health care system and society.

Such an approach makes no sense, says Benjamin F. Miller, PsyD, director, Eugene S. Farley, Jr. Health Policy Center, and assistant professor, department of family medicine, University of Colorado Denver School of Medicine.

Mental and physical health are profoundly interrelated. Medical conditions may lead to psychological problems, and psychological problems can impair physical health.¹²

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Integrated care 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, ineffective patterns of health care utilization.

— Lexicon for Behavioral Health and Primary Care Integration, Agency for Healthcare Research and Quality
For example, people with conditions such as diabetes and heart disease are more prone to depression and anxiety. Depression and anxiety can contribute to worsening health problems—even increased mortality. When mental and medical conditions co-occur—which they do frequently—it leads to worse symptoms, functional impairment, decreased length and quality of life, and increased costs.

The evidence has long shown that human behavior directly affects the way we deal with illness, manage chronic conditions and adhere to a care plan, Miller says. The current system isn’t addressing this, and it’s costly. A 1996 Institute of Medicine report concluded that mental health and primary care are inseparable, and attempts to separate them lead to inferior, more expensive, care.

“We have the business case—these individuals cost more,” says Miller. Integrated care addresses this by offering better access to treatment and improved health outcomes.

**Identification and assessment**

The inseparability of mental health from physical health is no longer at issue. The question, he says, is this: How will we change the health care delivery system to acknowledge that? “We have an opportunity to do something quite profound when it comes to addressing the needs of the whole person,” Miller says. “If the goal is to improve individual health, lower health care costs and improve the health of communities, it is imperative to understand that behavioral health is integral to physical health, and vice versa.”

More individuals with a diagnosable mental health condition are seen in primary care than any other setting, he says. So it makes no sense for the health delivery system to continue to silo them.

A wide range of behavioral health interventions can be offered by behavioral health providers in the primary care setting. Miller provided five categories.

- Addressing psychosocial barriers to care.
- Addressing evidenced-based interventions for lifestyle changes to improve physical health.
- Addressing mental health and substance use problems. This is the most common intervention.
- Addressing the needs of patients with multiple chronic conditions, both mental health and physical health concerns.
Addressing the needs of persons with severe mental illness (e.g., schizophrenia, bipolar disorder). Case managers may prove especially helpful in bridging the care gaps for these patients.

But primary care providers have not been encouraged to consult or collaborate with their behavioral health colleagues because of the current system’s design. They aren’t even equipped to make a diagnosis: In particular, depression remains undiagnosed among more than half of primary care patients.11

How a practice may identify those with behavioral health needs can vary. Maybe the front desk staff administers a screener, or maybe, as at Bon Secours, it’s part of rooming protocol. Miller offered a list of commonly used nonproprietary instruments for assessing behavioral health needs in primary care (see Figure 1). Although they do take some time to administer, most require very little effort to interpret.

Simply identifying need isn’t enough. Having the resources to interpret the results is also essential. That requires professionals with clinical judgment; professional case managers can take on this role. (See sidebar on page 4 for an example of how a Bon Secours pilot is accomplishing this.)

Among the other issues:

- Who is responsible for following up with the patient?
- Who retains the data from the assessment tool (and where)?
- Where will risk stratification come into play?
- How is the screening tool used to monitor treatment?

This last question is an important one: Screening tools aren’t merely for identifying patients who need behavioral health interventions. Just as a clinician uses the A1c as a measure of how well a patient with diabetes is doing, the PHQ-9 depression screen can be used repeatedly to assess the effectiveness of behavioral health interventions.

But there is a catch, and in the current fee-for-service environment, it’s a big one: time. No matter how effective the screening tool, it will meet resistance from providers and

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On Secours Medical Group is in the early stages of a pilot to put the principles of behavioral health integration into practice. Working with United Methodist Family Services (UMFS) in Richmond, Virginia, the initiative focuses on adolescent behavioral health. The site is a large family practice—11 doctors and three embedded RN case managers (referred to as “navigators”). Behavioral health specialists are co-located three days a week; the nurse navigators are there full time, explains Robert Fortini, PNP, chief clinical officer, Bon Secours Medical Group.

What’s been missing from the traditional referral approach is systematic, routine depression screening; it’s at the core of this pilot. The rooming protocol calls for each patient to be screened. The rooming staff asks the first two questions on the PHQ-9. If the patient scores 3 or higher, the navigator takes over and asks the other seven questions. For those with moderate depression, the navigator opens a new case management file. Those with severe depression are assigned to a behavioral health specialist.

The program is still working through growing pains. “Including behavioral health on the team has been an interesting experience,” says Fortini, who designed and championed implementation of the pilot. He shared some observations from the program’s first 60 days.

- **Expect initial resistance:** There was pushback from rooming staff and providers about the amount of time required to complete the depression screening and the accompanying documentation.

- **Training matters:** “As we train the rooming staff, rehearse scripts and simplify documentation tools and training, they are becoming more comfortable.” Likewise, as United Methodist provides more training, the navigators are more comfortable with triage.

- **Workflow must be adapted:** Rooming protocol, assessment, treatment algorithm, EHR workflows and access, credentialing with different payers, coding—all workflow aspects must be examined in the context of integrated care.

- **Clinician buy-in isn’t enough:** Getting the C-suite to embrace such a program can prove difficult, he says. And before anything can get underway, legal and compliance officers must sign off.

One of the biggest hurdles is the fee-for-service environment. But that will change, he says, and organizations working on integration will be well-positioned for the new value-based models.

That is the direction health care is headed. Penalties for increased utilization, coupled with the lure of shared savings in accountable models, make an integrated approach more attractive, says Fortini. And he’s already able to make the business case: The RN case manager and the behavioral health professional are invaluable in improving quality metrics and reducing gaps in care—especially in ACO-like contracts with commercial payers. “It’s huge. The case managers earn their salaries right there alone, just by plugging gaps in care.” And there’s the biggest benefit of all, he says—improved patient outcomes.

“Inevitably, inexorably, we’re moving to a value-based model.”
professional case manager can play an important role,” he says.

- Financing: Similarly, behavioral health and physical health each has a “different pot of money,” Miller says, making it difficult to collaborate as a team. “We often do not pay for the team, but rather for the individual service. In doing so, we perpetuate that false dichotomy. Every time we see them, we tell them they need to go somewhere else to have their have their needs taken care of.”

- Community expectations: Patients have come to expect that if they have a mental health complaint, there is a different path to care than for physical health.

- Training and education: Training for health care professionals must begin to focus on the whole person, not just the parts. It teaches providers to operate in their respective silos; it should instead focus on the team.

It’s no surprise, then, that most individuals with a behavioral health disorder remain untreated, Miller says. Meaningful change requires addressing the situation on all four fronts: “We have to address each one of these areas simultaneously.” Case managers can play a significant role in the overall integration of care.

Coordination of care around mental health is necessary, but far from sufficient. It’s just the first step.

Making it happen

The Agency for Healthcare Research and Quality’s Lexicon for Behavioral Health and Primary Care Integration describes three stages of the integration continuum: coordinated, co-located and integrated. It’s a simplified way to address the pathway, Miller says, but it’s nonetheless helpful.

- Coordinated: The first step is coordination of care. This is referral-based and relationship-driven. Clinical information exchange protocols are required so mental health clinicians and primary care professionals can be knowledgeable about all the patient’s health issues.

- Co-located: Embedding external specialty mental health services in the practice is the next step. It’s farther along the path toward integration, but it’s still referral-based and there are separate behavioral health and medical treatment plans.

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Integrated: Integration is the goal. This approach provides instantaneous, seamless access to the care the patient needs, be it physical or behavioral. It includes management of psychosocial aspects of chronic and acute diseases along with co-management of treatment of mental disorders and psychosocial issues.

Practices working towards integrated behavioral health are at various stages. “Find out what role you can play to move them toward better integration,” Miller tells professional case managers.

Efforts to enhance coordination of primary and behavioral care are expanding, but they are rarely sustainable. Reimbursement and billing challenges posed by fee-for-service medicine are the greatest barrier to creating and maintaining integrated care practice—specifically, physical and mental health reimbursement.14 15 say Miller and Fortini. It follows, then, that the way to make integration efforts sustainable is to change the fee-for-service model.

That will happen, says Patrice Sminkey, CEO of the Commission for Case Manager Certification16. She notes that the Department of Health and Human Services announced that by 2018, half of Medicare’s direct payments will be value-based to align with the Triple Aim of better care, better health and lower costs.16 That’s just one example, she says. “Recognition that cost and quality must be part of the equation means the demand for board-certified case managers will continue to increase.”

Changes won’t happen overnight, but one milestone on that path is team-based care—a sweet spot for the professional case manager. If anyone understands the continuum of care and how patients can get lost in the system—and can figure out how to help them—it’s case managers, says Fortini.

Miller offers a few tips to case managers who want to advocate a more integrated approach.

14 Kathol, Psychosomatic Medicine op. cit.
15 Smith, C. “Beyond a Fad: How Integrated Care Can Swim to the Mainstream, Collaborative Family Healthcare Association blog, April 21, 2011
16 Developed by the Institute for Healthcare Improvement

"Recognition that cost and quality must be part of the equation means the demand for board-certified case managers will continue to increase."
— PATRICE SMINKEY, CHIEF EXECUTIVE OFFICER, COMMISSION FOR CASE MANAGER CERTIFICATION

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— ROBERT FORTINI, PNP, VICE PRESIDENT AND CHIEF CLINICAL OFFICER, BON SECOURS MEDICAL GROUP
Decide how you are going to implement and measure. You can use that data to make the case for your integration efforts.

Finally, he says, keep your goal in sight. “The end goal is the Triple Aim. If what you’re doing doesn’t touch on this, it probably won’t last for long.”

Patients are walking a different path than the one paved by the health care delivery system, Miller says. It’s time to meet patients where they are. “We have an opportunity to create a more patient-centered solution by integrating care, by creating a system that addresses the whole person.”

Integrated, connected care dovetails into what board-certified case managers do, says Sminkey. “As case managers, we know how to optimize healing, paying special attention to the emotional, social, financial and health needs of our clients. Initiatives such as these that champion integrated behavioral health and total care management are the heart of our continuing evolution toward more patient-centered, effective, cost-efficient care.”

“We have an opportunity to create a more patient-centered solution by integrating care, by creating a system that addresses the whole person.”

— BENJAMIN F. MILLER, PSYD, DIRECTOR, EUGENE S. FARLEY, JR. HEALTH POLICY CENTER, ASSISTANT PROFESSOR, UNIVERSITY OF COLORADO DENVER SCHOOL OF MEDICINE

About the Experts

Patrice Sminkey, Chief Executive Officer, The Commission for Case Manager Certification

Sminkey comes to the Commission from URAC, where she most recently served as senior director of sales. Prior to that, she was senior vice president, operations and client management, Patient Infosystems in Rochester, N.Y. She brings a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. She has extensive experience in client management and coordination, including marked improvement in client retention, timely and fiscally sound program implementation and an expanding book of business.

As chief executive officer, Sminkey oversees the management of all activities related to the Commission’s operations, including all programs, products and services; and the provision of quality services to and by the Commission. She is a direct liaison to the Commission’s Executive Committee. She works with CCMC’s volunteer leadership to evaluate and develop potential new products for implementation by CCMC, and she establishes and maintains communication and working relationships with other organizations, agencies, groups, corporations and individuals.

She holds a diploma of nursing from the Chester County School of Nursing.
Benjamin F. Miller, PsyD
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Miller is an assistant professor in the Department of Family Medicine at the University of Colorado Denver School of Medicine where he is also the director of the Eugene S. Farley, Jr. Health Policy Center. He is a principal investigator on several federal and foundation grants, as well as state contracts related to comprehensive primary care and mental health, behavioral health, and substance use integration. He leads the Academy for Integrating Behavioral and Primary Care project for the Agency for Healthcare Research and Quality (AHRQ), as well as the Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) project. He has published extensively in the area of integrated behavioral health and primary care.

He received his doctorate in clinical psychology from Spalding University in Louisville, Kentucky. He completed his predoctoral internship at the University of Colorado Health Sciences Center, where he trained in primary care psychology.

Miller is the co-creator of the National Research Network’s Collaborative Care Research Network, and has written and published on enhancing the evidentiary support for integrated care. He is the section editor for Health and Policy for Families, Systems and Health and reviews for several academic journals. Miller is a technical expert panelist on the AHRQ Innovations Exchange and on the International Advisory Board of the British Journal of General Practice. Miller is a past president of the Collaborative Family Healthcare Association and is faculty for the Institute for Healthcare Improvement.

Robert Fortini, PNP
vice president and chief clinical officer
Bon Secours Medical Group

Fortini is vice president and chief clinical officer for Bon Secours Medical Group in Richmond, Virginia. He is responsible for facilitating provider adoption of EMR, coordinating clinical transformation to a patient-centered medical home care delivery model, and facilitating participation in available pay-for-performance initiatives as well as physician advocacy and affairs. He has extensive experience in operations and clinical policy development, and experience in workflow re-engineering and CQI in ambulatory care. Before coming to Bon Secours, he served as the chief medical affairs officer at Queens Long Island Medical Group, engaged in quality and health IT adoption. He successfully applied for the first Level 3 NCQA-recognized PCMH in New York state. Prior to that, at Community Care Physicians Medical Group, Fortini participated in the successful launch of the Bridges to Excellence Collaborative in upstate New York. He has 30 years of experience in health care. He is a graduate of Fordham University and the State University of New York College of Health Professions at Upstate Medical Center in Syracuse.