

Primary Care Behavioral Health Integration: Promoting the Quadruple Aim

Eric Christian, Valerie Krall, Stephen Hulkower, Sue Stigleman

Chronic medical and common behavioral health conditions have been shown to benefit from team-based care approaches that include integrated behavioral health providers. Team-based integrated care can promote the Quadruple Aim, encompassing health care outcomes, patient satisfaction, provider work/life experience, and the cost of care.

Our current US health care system is undergoing massive structural reform as it moves to meet expectations of a future payment system predicated on value-based outcomes. Integrated care practice models meet this challenge as chronic medical and common behavioral health conditions have been shown to benefit from team-based care approaches that include integrated behavioral health providers [1-3]. It is well known that integrated care has been utilized as a model for some North Carolina health care provision, but many clinics that fall short of operating under its tenets may face challenges in meeting both their populations' presenting medical and behavioral health needs, and the trend toward value-based outcomes. Integrated care is defined as "the seamless and dynamic interaction of primary care providers (PCPs) and behavioral health providers (BHPs) working within one agency providing both counseling and traditional medical care services [4]." Integrated care requires a team-based approach in both implementation and execution. This article aims to describe how team-based integrated care is feasible and has the ability to promote the Quadruple Aim, encompassing health care outcomes, patient satisfaction, provider work/life experience, and the cost of care [3, 5].

In addition to crisis management and counseling, successful integrated care provides patients with systematic follow-up, ample education in the collaborative processes of caring for their condition, and ideally, readily available care management services [6]. Integrated care allows BHPs to receive "warm handoffs" of patients from PCPs and perform brief interventions. This permits face-to-face discussions to relay concise medical and psychosocial histories and clear goals of care in the presence of the patient. BHPs also act as liaisons to consulting psychiatrists who may, through case review, telehealth, or in-person evaluation, help clarify complex diagnoses and management of treatment plans. Additionally, BHPs may be involved in activities outside of

typical mental health and/or substance use concerns, as when partnering with pharmacists and PCPs in chronic pain and metabolic groups or using motivational interviewing with patients for medication management. Shared space, exposure to daily clinical encounters, interprofessional education, brief lectures, case presentations, and shared common psychoeducational materials allow all team members to learn about one another's skill sets and build team cohesion.

In recent years, changes in Medicaid policies put forth by the NC Division of Medical Assistance have supported integrated care by offering flexibility for a limited number of brief interventions provided by BHPs in integrated care settings without requiring the same level of assessment and formal treatment planning mandated in traditional mental health agencies [7]. This change has helped to move the integrated care concept forward as it leads to patients receiving more immediate treatment when specific behavioral health needs are identified by their PCPs.

For clarity, the authors will sort integrated programs into two categories: integrated care models and integrated care hybrids. Integrated care models have formats with defined metrics and return on investment; when replicated to fidelity, similar results would be produced. Integrated care hybrids are program variations of existing models and may be utilized if an integrated care model's resources are not fully available, sufficient clinic support is unavailable, or additional needs or resources are identified. Integrated care models and their constructs can exist within larger hybrid programs set up to accommodate additional functions. A side-by-side comparison of the models can be found in Table 1, and it is important to note that more than one model can exist within a single site.

The Primary Care Behavioral Health (PCBH) model is a population-based service in which the BHP is available to PCPs and patients on the clinic floor, and for phone and electronic communications, so is therefore minimally sched-

Electronically published July 6, 2018.

Address correspondence to Eric Christian, Community Care of Western North Carolina, 53 S. French Broad Ave., Ste. 300, Asheville, NC 28801 (echristian@ccwnc.org).

NC Med J. 2018;79(4):250-255. ©2018 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2018/79413

TABLE 1.
Integrated Care Models

	BHP Staff	Patient Registry	Real Time Availability for Consult or Intervention	Planned BH Appointments/ Follow-ups	Conditions Treated	Psychiatric Consultation	Cost Savings over Usual Care	Team-Based Care Approach
Primary Care Behavioral Health (PCBH)	Core Element	Helpful for high-risk groups	Core Element	Some planned follow-ups w/BHP	All	Optional and helpful	✓	✓
Collaborative Care Management (CoCM)	Core Element	Core Element	Optional if available to meet patient	Core Element	Depression, anxiety and some chronic physical health conditions	Core Element	✓	✓
Screening Brief Intervention and Referral to Treatment (SBIRT)	Optional Enhancement	Core Element for high-risk groups	Optional and ideal if BHP is available	As needed for each patient	Alcohol and drug use concerns	Optional and helpful	✓	✓

Sources: 3, 8, 9, 10, 12, 15, 16, 17.

uled. BHPs function as generalists who are visibly part of the medical team during patient appointments for consults to the PCP, and/or for frequent warm handoffs. BHPs assist in diagnosis and triage and provide psychoeducation and brief interventions such as teaching relaxation or grounding skills for various behavioral health conditions like sleep issues and anxiety. Services match the pace of primary care and are focused on maximizing patient functionality and self-management, with BHP encounters averaging less than 30 minutes [8, 9], providing 1 to 4 consults per patient complaint, and seeing 10 to 15% of patients for longer durations [8]. PCBH has been shown to be effective when targeting about 16% of the clinic's patients seen per day, addressing routine as well as complex patient presentations [3]. Reiter states that PCBH models retain about 90% of behavioral health concerns and refer more acute cases to collaborating specialty mental health providers [10]. Reduced costs for patients treated in the PCBH model lead to greater patient satisfaction [1, 2, 10]. In addition, utilization of PCP visits has been shown to be lower during the BHP's service period and for up to 12 months thereafter with significant improvement over usual care, even for patients with severe and persistent mental illness [11, 12]. Furthermore, PCBH in pediatric settings allowed PCPs to serve 42% more patients per day, yielding an additional \$1,142 in revenue [3].

Practices can create hybrid programs to fit their unique practice needs and available resources while striving for PCBH's proven components. Various pediatric and family medicine practices and health departments in North Carolina have also employed BHPs to provide co-located or partially integrated care. In addition to PCP practices, developmental pediatricians and sub-specialists such as pediatric gastroenterologists have successfully integrated BHPs into their teams.

The Mountain Area Health Education Center (MAHEC)

Family Health Center and Family Medicine Residency Program utilizes a hybrid approach similar to the PCBH model, with additional services included. PCPs at the center often prefer "co-management" of care rather than referral to community mental health and may request longer-term in-house treatment for patients with more complex needs. Patients also often request integrated care behavioral health services for reasons such as convenience, desire for team-based care, preference for individual versus group counseling, and difficulty accessing community services. Patient and provider satisfaction were supported by data collected at the center in 2016. Satisfaction surveys given to 59 providers at MAHEC (faculty physicians, residents, advanced practice providers, and pharmacists), and 175 patients receiving follow-up behavioral health services there found: 98.3% of providers indicated benefit from patient care co-management with BHPs, and 98.3% of patients responded that if a friend needed counseling services they would recommend the center (MAHEC Family Health Center, unpublished data). Similar findings for residents' satisfaction within an integrated care setting can be found in the study by Hill [13]. The capacity of in-house behavioral health services and access to care for new referrals must be closely monitored to avoid excessive wait times.

Enhanced patient and provider satisfaction have been amply demonstrated by integrated care studies [13-14, 16]. "One-stop shopping" to receive mental health care in a familiar primary care setting in collaboration with a valued PCP is a welcoming and reassuring incentive for patients who may otherwise be reluctant to pursue treatment. Shared electronic health records and "hallway conversation" among team members results in improved coordination of care. A study of 27 primary care pediatric providers at 11 urban and rural clinical sites showed that 96% were enthused about the value of integrated care related to perceptions of

reduced patient stigma, improved continuity, quality of care, outcomes, and patient follow-up. Satisfaction with cost reduction was expressed by PCPs in urban integrated care models, while there was an even split in perception among those in rural clinics [14].

The Screening Brief Intervention and Referral to Treatment (SBIRT) model provides prevention-based early detection through population-wide screening for at-risk drinking and/or drug use, followed by stepwise intervention. Here the PCP and/or BHP provides the conversational space to contextualize risky behaviors using a motivational interviewing approach in which assessment findings and dialogue with the patient assist in the formation of a realistic personal treatment goal that leans on the patient's impetus for change, rather than that of the provider. Reducing the risk of losing employment, improving relationships strained by substance use, or reducing alcohol consumption to improve a health condition such as uncontrolled hypertension are

examples of where this targeted approach—which includes timely follow-up and sometimes a referral out—has shown reduction in risky behaviors (39% for alcohol and 68% for drug use), a rise in show rates for specialty treatment (from 5% with usual care to at least 55%) and a 4-fold return on investment [15].

The Collaborative Care Management (CoCM) model adds an embedded care manager trained in behavioral activation strategies and problem-solving treatment approaches derived from cognitive-behavioral therapy. Here, the PCP identifies patients with elevated depression and anxiety scores in standardized instruments, such as the PHQ-9 for depression and the GAD-7 for anxiety, and invites them into the CoCM program. The CM assesses the patient, provides biweekly phone or in-person interventions, and repeats instrument implementation to track progress. The CM and a consulting psychiatrist meet weekly to review a caseload registry; psychiatrists make recommendations for treatment

for an average of 70% of these patients, which sometimes leads to medication changes by PCPs. A 2014 report prepared for the American Psychiatric Association summarized numerous studies and randomized controlled trials and found the average cost savings per patient per month in the CoCM model ranged from \$39 to \$70 when compared to usual care. CoCM patients were 54% less likely to use emergency services and 49% less likely to need psychiatric inpatient treatment [16]. This rigorous protocol allows for longitudinal tracking and a focus on "treating to target." Medicare piloted and has now approved team-based care coding for this model. When depression improvement is considered, as determined by a 50% or greater reduction in symptoms, 45% of CoCM patients demonstrate improvement compared to only 19% of those in usual care [17].

A team-based care approach is essential to successfully functioning integrated care models and hybrids and supports the Quadruple Aim. Successful team-based care must include 3 essential teamwork factors: knowledge about the way a set of skills and behaviors coalesce, skills to optimize teamwork and foster anticipation of each other's actions, and teamwork-related attitudes [18]. Awareness of fellow team members' skills can increase efficiency by avoiding duplication of duties and tasks and allowing team members to proactively help one another and foresee opportunities for coordination of care and support. Joint meetings and trainings on team-based treatment processes and their associated workflows can lead to better understanding of one another's roles, challenges, and ways to support others on the team.

Though all family medicine residencies require some level of behavioral health training, MAHEC provides a notable example of training new providers in team-based care while simultaneously providing patients with a robust integrated care service. Residents co-manage patient care alongside BHPs, BHP interns, and other members of the team including nurses, pharmacists, nutritionists, librarians, and care managers. Additional aspects of fully integrated care practice in academic medical centers include comprehensive integrated care education, research, and training in medical schools and residencies [19].

Federal funding has been made more widely available to behavioral health graduate school programs to support curriculum changes and training to equip students with integrated care skills. Behavioral health interns working in integrated care clinics have made it possible for uninsured patients to receive short-term services to which they may not have otherwise had access within their medical home. Federal technical assistance grants, such as the Practice Transformation Network (PTN) grant, provide structured technical assistance using a standardized assessment and planning tool like the Maine Health Access Foundation's Integrated Care Initiative Site Self-Assessment to yield expedited and better integration level outcomes [20]. Community Care of North Carolina provides PTN technical assistance, and the Center of Excellence for Integrated Care, a program of the Foundation for Health Leadership & Innovation, has provided integrated care technical assistance since 2006.

Team-based documentation of patient care has been found to be conducive to integrated care and is an important aspect of physician satisfaction and improved work/life experience [5]. BHPs must follow rules for documentation, billing/coding, and reimbursement factors at federal and state levels. Creating clinic work groups to proactively build the necessary workflows and systems to support a BHP is essential and can reduce risk of revenue being lost during start-up [21]. Communication with managed care organizations as well as with clinic administrators helps in gaining clarity, achieving consistency, and properly interpreting guidelines, which ensures compliance [22].

Cost savings with integrated care application arise from several factors, one of which is more efficient primary care office visits with readily available help for complex psychosocial problems or crises—a significant percentage of the problems encountered in primary care [2-3, 10]. Additional cost savings arise from quicker patient stabilization, lower no-show rates for Medicaid patients, and expedited psychiatry consultations [17, 23, 24]. A 4-year retrospective longitudinal study of 113 practices determined that team-based integrated care was superior to usual care, with demonstrated improvement in medication adherence [2, 6], screening for depression, diabetes therapy adherence, and a decrease in emergency department visits [2]. Although there are initial start-up costs with integrated care, when

considered with the overall costs, it was less costly than usual care [2]. Patient value in integrated care was also clearly recognized by English in his retrospective look at over 113,000 patients treated in either integrated care or usual care, demonstrated by increased quality and decreased amount of care needed [1].

While remarkable benefits are fully realized with implementation over time, integrated care is more expensive and resource-dependent at the start of transition and will only be sustainable if improved outcomes, patient and provider satisfaction, and cost savings can be realized [6]. Moreover, payment reform is necessary to allow integrated medical and behavioral health teams to collaborate. Global payment structures (capitation) provide the best model for enabling and sustaining integrated care in a PCMH setting [25]. Value-based payments to practices have been shown to improve practices' fidelity to the integrated care model, and most importantly, patient outcomes [24].

Conclusion (recommendations)

Integrated care does not replace the specialty behavioral health system, but rather enhances the way common patient concerns revealed in primary care (the largest point of entry into the health care system) are addressed, thereby strengthening the continuum of care from primary to specialty settings. NCMJ readers should consider how their team-based care approaches could be bolstered by integrated care, what help is available to them, and the next small steps that could be taken toward increasing their level of integration as they strive to achieve the goal of the Quadruple Aim. NCMJ

Eric Christian, MAEd, LPC, NCC director of behavioral health integration, Community Care of Western North Carolina, Asheville, North Carolina; integration specialist, Center of Excellence for Integrated Care, Foundation for Health Leadership & Innovation, Cary, North Carolina.

Valerie Krall, MA, LPC behavioral health faculty, Division of Family Medicine, Mountain Area Health Education Center, Asheville, North Carolina.

Stephen Hulkower, MD director, Division of Family Medicine, Mountain Area Health Education Center, Asheville, North Carolina.

Sue Stigleman, MLS clinical and research librarian, Division of Family Medicine, Mountain Area Health Education Center, Asheville, North Carolina.

Acknowledgments

Potential conflicts of interest. All authors have no relevant conflicts of interest.

References

1. English AF. Team-based primary care with integrated mental health is associated with higher quality of care, lower usage and lower payments received by the delivery system. *Evid Based Med.* 2017;22(3):96.
2. Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of integrated team-based care with health care quality, utilization, and cost. *JAMA.* 2016;316(8): 826-834.
3. Gouge N, Polaha J, Rogers R, Harden A. Integrating behavioral health into pediatric primary care: implications for provider time and cost. *South Med J.* 2016;109(12):774-778.
4. Curtis R, Christian E, eds *Integrated care: applying theory to practice.* New York, NY: Routledge/Taylor & Francis; 2012.
5. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med.* 2014;12(6):

- 573-576.
6. Vogel ME, Kanzler KE, Aikens JE, Goodie JL. Integration of behavioral health and primary care: current knowledge and future directions. *J Behav Med.* 2017;40(1):69-84.
 7. North Carolina Division of Medical Assistance. Behavioral health clinical coverage policy No. 8C: outpatient behavioral health services provided by direct-enrolled providers. Raleigh, NC: North Carolina Division of Medical Assistance; July 1, 2017. https://files.nc.gov/ncdema/documents/files/8C_O.pdf. Accessed April 19, 2018.
 8. Robinson PJ, Reiter JT. Behavioral Consultation and Primary Care: A Guide to Integrating Services. 2nd ed. New York, NY: Springer Publishing Co; 2016.
 9. Hunter CL, Goodie JL, Oordt MS, Dobmeyer AC. Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention. Washington, DC: American Psychological Association; 2009.
 10. Reiter JT, Dobmeyer AC, Hunter CL. The primary care behavioral health (PCBH) model: an overview and operational definition. *J Clin Psychol Med Settings.* doi: 10.1007/s10880-017-9531-x.
 11. Davis D, Corrin-Pendry S. A follow-up study of the long-term effects of counselling in a primary care counseling psychology service. *Coun Psychol Res.* 2008;8(2):80-84.
 12. Schmit MK, Watson JC, Fernandez MA. Examining the effectiveness of behavioral and primary health care treatment. *J Couns Dev.* 2018;96(1):3-14.
 13. Hill JM. Behavioral health integration: transforming patient care, medical resident education, and physician effectiveness. *Int J Psychiatry Med.* 2015;50(1):36-49.
 14. Hine JF, Grennan AQ, Menousek KM, Robertson G, Valleley RJ, Evans JH. Physician satisfaction with integrated behavioral health in pediatric primary care. *J Prim Care Community Health.* 2017;8(2):89-93.
 15. Estee S, Wickizer T, He L, Shah MF, Mancuso D. Evaluation of the Washington state screening, brief intervention, and referral to treatment project: cost outcomes for Medicaid patients screened in hospital emergency departments. *Med Care.* 2010;48(1):18-24.
 16. Melek SP, Norris DT, Paulus J. Economic Impact of Integrated Medical-Behavioral Healthcare. Denver, CO: American Psychiatric Association; 2014.
 17. Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA.* 2002;288(22):2836-2845.
 18. Baker DP, Gustafson S, Beaubien JM, Salas E, Barach P. Medical team training programs in health care. Rockville, MD: Agency for Healthcare Research and Quality; 2005. <https://www.ahrq.gov/downloads/pub/advances/vol4/Baker.pdf>. Accessed April 19, 2018.
 19. Taylor JB, Ferris TG, Weilburg JB, Alpert JE. Behavioral health integration: challenges and opportunities for academic medical centers. *Acad Psychiatry.* 2016;40(6):874-879.
 20. Roderick SS, Burdette N, Hurwitz D, Yeracaris P. Integrated behavioral health practice facilitation in patient centered medical homes: a promising application. *Fam Syst Health.* 2017;35(2):227-237.
 21. Krall V. Integrating a behavioral health provider into an existing medical practice: practical steps to consider. In: Craig WS, ed. *Integrated Psychological Services in Primary Care.* Hauppauge, NY: Nova Science Publishers; 2015:31-53.
 22. Krall V, Boice D, Christian E, Wilson P, Hartye J. How multi-sector collaboration can help you prepare your integrated care site for audits while improving patient care and building efficiency along the way. 2016.
 23. Guck TP, Guck AJ, Badura Brack A, Frey DR. No-show rates in partially integrated models of behavioral health care in a primary care setting. *Fam Syst Health.* 2007;25(2):137-146.
 24. Bao Y, McGuire TG, Chan YF, et al. Value-based payment in implementing evidence-based care: the Mental Health Integration Program in Washington state. *Am J Manag Care.* 2017;23(1):48-53.
 25. Miller BF, Ross KM, Davis MM, Melek SP, Kathol R, Gordon P. Payment reform in the patient-centered medical home: enabling and sustaining integrated behavioral health care. *Am Psychol.* 2017;72(1):55-68.