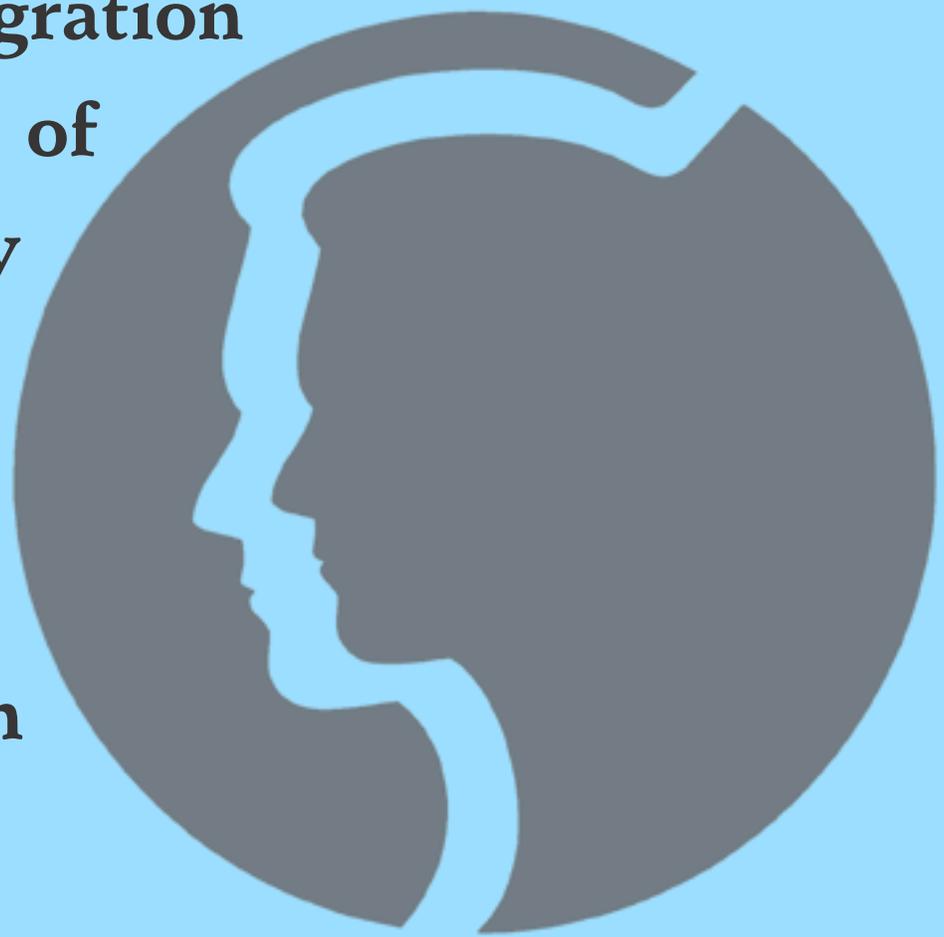
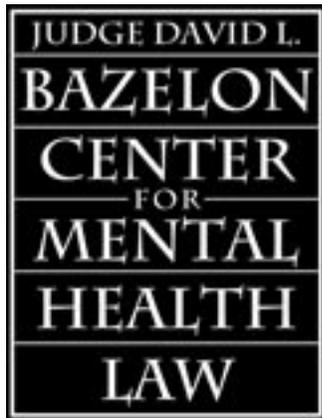


**Integration  
of  
Primary  
Care  
and  
Behavioral  
Health**



**Report on a Roundtable Discussion of  
Strategies for Private Health Insurance**

BAZELON CENTER FOR MENTAL HEALTH LAW  
1101 Fifteenth Street NW, Suite 1212  
Washington DC 20005  
202-467-5730  
fax 202-223-0409  
pubs@bazelon.org  
www.bazelon.org



©Copyright February 2005 Washington DC Judge David L. Bazelon Center for Mental Health Law

**The Bazelon Center** is the leading national legal-advocacy organization representing people with mental disabilities. Founded in 1972, the nonprofit organization uses litigation, public-policy advocacy

and technical support for lawyers and other advocates to establish and advance the rights of adults and children with mental illness or developmental disabilities who rely on public services and to ensure their equal access to health and mental health care, education, housing and employment.

**This Report on Strategies for Private Health Insurance** was written by Elaine Alfano, Bazelon Center policy analyst, and edited and designed by publications director Lee Carty. It is a companion document to **GET IT TOGETHER**, the Bazelon Center's report on integration of health and behavioral health care in the public sector. We gratefully acknowledge the support provided by CIGNA Healthcare for the roundtable and drafting of this report and the general-program support of the John D. and Catherine T. MacArthur Foundation, which enabled the design and production of this document.

The report is available on the Bazelon Center's website, [www.bazelon.org](http://www.bazelon.org), or send \$4 per copy (includes postage and handling) to the Publications Desk at the Bazelon Center. Print copies of both publications can be ordered from the online bookshop; visit [www.bazelon.org/publications](http://www.bazelon.org/publications).

# CONTENTS

## **Integration of Primary Care and Behavioral Health**

|  |    |
|--|----|
| INTRODUCTION   | 1  |
| SECTION ONE  |    |
| BARRIERS TO INTEGRATION  | 3  |
| Financial Barriers   | 3  |
| Differences in Culture and Practice                                  | 3  |
| Training Issues  | 3  |
| Information Systems and Privacy Protections                          | 3  |
| Consumer Issues and Concerns   | 3  |
| SECTION TWO  |    |
| GENERAL DISCUSSION OF TOPICS AND RECOMMENDATIONS                     | 5  |
| Fiscal Issues Drive the Context                                      | 5  |
| Collaboration Is Needed to Make the Case for Integration             | 5  |
| Key Characteristics of Integrated Practices                          | 6  |
| Growing New Integrated Practices                                     | 5  |
| Parity in Coverage Is Critical                                       | 7  |
| Carve-Outs Discourage Integration of Care                            | 7  |
| Continuity of Care Is Important                                      | 7  |
| Reimbursement Practices Need to Change                               | 7  |
| Provider Practices Must Also Improve                                 | 9  |
| Collaborative Approaches to Change Work Best                         | 9  |
| Targeted Screening Pays Off  | 10 |
| Screening Is Essential and Can Be Simple                             | 10 |
| Screening Should Be Universal  | 11 |
| Providers and Consumers Need Education on Screening                  | 12 |
| To Improve Treatment: Engage Consumers                               | 12 |
| To Improve Treatment: Enlist Employers                               | 13 |
| To Improve Treatment: Coordinate Care                                | 13 |
| To Improve Treatment: Disease Management                             | 14 |
| To Improve Treatment: Medication Management                          | 15 |
| To Improve Collaboration: Flexible Approaches to Co-Location         | 15 |
| To Improve Collaboration: Share Information                          | 16 |
| Re-Tool to Support Integration                                       | 17 |
| SECTION THREE  |    |
| RECOMMENDATIONS  | 18 |
| General Recommendations  | 18 |
| Recommendations for Primary Care Providers                           | 18 |
| Recommendations for Health Plans                                     | 19 |
| Recommendations for Employers as Purchasers of Health Care           | 20 |
| Recommendations for Academic Institutions and Professional Societies | 20 |
| Recommendations for State and Federal Policymakers                   | 21 |
| CONCLUSION   | 22 |
| NOTES  | 23 |
| PARTICIPANTS   | 24 |

PAGE INTENTIONALLY BLANK

# Integration of Primary Care and Behavioral Health

## INTRODUCTION

On September 13-14, 2004, the Bazelon Center hosted a roundtable in Washington DC to discuss strategies for integration of primary care and behavioral health in the context of private health insurance. The group included health care leaders with expertise in primary care, mental health and substance abuse services, and public and private-sector health plan policy, purchasing and administration (see participant list).

The Roundtable followed the release in June 2004 of a Bazelon Center report, *Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders*. This study of public-sector initiatives highlights findings from a literature review and reviews model programs for improving integration and coordination of behavioral health and primary health services for adults and children with serious mental or emotional disorders. The report also offers recommendations for policymakers.

Individuals with serious mental disorders who receive most of their care in the public mental health system have been (and will remain) a priority for the Bazelon Center's advocacy. The *Get it Together* study was conducted to fill a gap in public-policy research. Most

such research and demonstration projects focus on improving care for adults with mild to moderate depression or children with attention deficit hyperactivity disorder (ADHD). Yet ignoring populations with other serious mental illnesses and substance abuse disorders is costly,

both socially and economically, because these individuals are unlikely to receive appropriate preventive and primary care, despite being at greater risk for co-occurring diseases and chronic conditions. We believed it was important to examine approaches to integration of the services they require.

The intent of the Roundtable was to complement our study of public-sector initiatives to integrate care by turning attention to private-sector efforts. While the two sectors tend to operate on parallel tracks and may be financed differently, they are not entirely independent of each other. They have many issues in common and their service systems intersect in various ways. For example, many primary care providers see clients in both realms, and the individuals themselves may move between systems.

Clearly, opportunities exist for both the public and private systems to have an impact upon and contribute

**Enlisting behavioral health providers' assistance to ensure that individuals with behavioral health conditions receive appropriate primary and preventive care will be of value as our nation strives to eliminate avoidable health disparities and the fiscal and social costs associated with chronic conditions and diseases.**



to overall improvement in health care quality. Efforts, for example, to increase the behavioral health skills and competencies of the primary health care workforce will yield improvements in the care of all individuals, whether commercially insured or covered by Medicaid. Enlisting behavioral health providers' assistance to ensure that individuals with behavioral health conditions receive appropriate primary and preventive care will likewise be of value as our nation strives to eliminate avoidable health disparities and the fiscal and social costs associated with chronic conditions and diseases.

Believing that there is great potential for public and private health care plans to benefit from each others's experiments and experiences, the Bazelon Center convened the Roundtable to learn about successful innovations and strategies in the private sector and to consider whether and how approaches in one realm might effectively be deployed in the other. Against this backdrop, we asked Roundtable panelists to develop a set of recommendations for addressing the problems of a fragmented and uncoordinated service system.

The Bazelon Center would like to thank the participants, who generously gave their time and attention to the Roundtable, and the CIGNA Corporation, for underwriting the meeting's costs. We appreciate the participants' thoughtful contributions and hope that this summary report captures the spirit of the proceedings and the excellent ideas they put forward.

## **Contents of the Report**

Over the course of the two-day Roundtable, our panel developed recommendations for improving health care quality through integration. They offered concrete ideas for key stakeholders, including providers, health plans, purchasers, public policymakers, medical educators and professional societies. The recom-

mendations range widely, touching upon issues of clinical practice, public policy, professional training, financing and reimbursement, practice management, administrative systems, health plan policies and administration, accountability, and employee and consumer assistance.

While this report reflects the discussion and the recommendations put forth by Roundtable members, it should be noted that the author has taken the liberty of adding some supplemental information—both to

translate the group's shorthand and to expound on some of the topics in more detail.

The report is divided into four sections:

- ◆ Section One summarizes barriers to the integration of care.
- ◆ Section Two is a narrative discussion of the issues and recommendations that were put forward at the Roundtable.
- ◆ Section Three is a list of recommendations organized by stakeholder group.
- ◆ Section Four offers some final analysis and concluding remarks.

**The recommendations range widely, touching upon issues of clinical practice, public policy, professional training, financing and reimbursement, practice management, administrative systems, health plan policies and administration, accountability, and employee and consumer assistance.**



## SECTION ONE

### BARRIERS TO INTEGRATION

Because Roundtable participants were keenly aware of the problems of care-fragmentation and barriers to integration, we did not set aside time for exhaustive discussion of these issues, preferring to use the time to focus on solutions. For context, however, the Bazelon Center provided a list of barriers gleaned from literature reviews and interviews conducted for the *Get it Together* study.

#### **Financial Barriers**

- ◆ Reimbursement practices favor shorter office visits, thereby discouraging identification of issues beyond the primary presenting disorder.
- ◆ Providers are not compensated for time spent communicating with colleagues.
- ◆ Mental health is carved out from the health plan, resulting in a lack of accountability and transparency about which entity is responsible for payment, care coordination and quality.
- ◆ Reimbursement practices create financial incentives to perform procedures and diagnostic tests and fail to adequately recognize the value and complexity of screening and treating mental health disorders in primary care.
- ◆ A third-party payment system gives weighted value to specialty care while undervaluing primary care and the difficulty of care integration.

#### **Differences in Culture and Practice**

- ◆ Fundamental differences in working styles and communications practices among provider types discourage natural alliances and close working relationships. For example, psychiatrists typically will not accept calls when seeing patients, while primary care providers may take calls from colleagues at almost any time.
- ◆ The professional isolation of mental health and substance abuse treatment providers from other health care practitioners leads to a lack of understanding of

differences in clinical and administrative procedures in the other's milieu.

- ◆ Medical school and residency programs tend to emphasize the technical, biomedical aspects of care, often ignoring the psychosocial aspects of health status.
- ◆ For various historical reasons, mental health treatment may appear to be substantially different from the rest of health care. Some physicians view substance abuse services as even more distant from mainstream medicine.
- ◆ Historically, some substance abuse treatment programs have discounted pharmacological treatment altogether, leading to conflicts in the field itself and with mental health and general medicine about the concurrent use of medications.
- ◆ Because of skepticism or unfamiliarity with mental health and substance abuse treatment, primary care physicians may overlook signs of behavioral health disorders or fail to refer on the assumption that treatment will not help. The view among some substance abuse treatment providers that physicians routinely ignore substance abuse problems contributes to the problems associated with practice differences.

#### **Training Issues**

- ◆ Numerous studies examining the poor rate of recognition of mental disorders in primary care settings show that one half to two thirds of those with diagnosable mental disorders go unrecognized. Insufficient knowledge of diagnostic criteria may be a factor related to this low rate of recognition.
- ◆ Many primary care physicians feel they lack sufficient decision support to help them decide which patients to refer and which to manage themselves. They feel they have not received sufficient training in psychiatry, nor are they given practice guidelines that emphasize integration of mental health and primary



care services. Typically, family physicians and mid-level practitioners are more comfortable with the bridge between behavioral health and primary care due to the orientation of their training.

- ◆ Pediatricians consistently report that pediatric residencies do not adequately prepare them to treat patients with learning disabilities, attention deficit disorders, mental retardation, substance abuse issues or psychosocial and behavioral problems.
- ◆ Psychiatric specialty education does not provide sufficient training in primary care and the interactions and effects of co-existing medical disorders and psychiatric conditions.
- ◆ Neither primary care physicians nor psychiatrists receive significant training in collaborative practice arrangements. Medical schools do not emphasize working as part of an interdisciplinary team.

### **Information Systems and Privacy Protections**

- ◆ Medical records in primary care are short summaries of diagnoses, treatments and outcomes, while mental health and substance abuse plans are long and detailed, with multiple objectives and issues that must be addressed for recovery. When faced with this onslaught of information, primary care providers may be frustrated in trying to locate the specific information they seek.
- ◆ Differences in information-sharing practices can significantly hamper the provision of integrated care. Software incompatibility and differences in how information is recorded make it difficult to share necessary information from medical records, devise workable reporting forms or even share scheduling information.
- ◆ Privacy rules and professional practice standards require that consumers sign a release before information about them can be shared. While some consumers may not agree to sign such an authorization, opportunities are missed when providers fail to ask or explain why this sharing of information would be of value.
- ◆ Health plans could use the information they amass to give important feedback to providers about prac-

tice patterns and whether they comport with quality guidelines, but this opportunity for quality improvement is mostly missed. This kind of information—if shared with the provider and combined, when appropriate, with educational measures—has the potential to change practices and contribute to improved care.

### **Consumer Issues and Concerns**

- ◆ While some consumers may prefer to be treated in a primary care setting for both physical and behavioral health, others prefer to keep mental health and substance abuse care separated. These preferences may stem from experiences related to stigma or because consumers had prior negative experiences with one type of provider or the other.
- ◆ Lack of parity in insurance coverage, limited provider panels and other financial issues contribute to a “forced choice” that may not reflect individuals’ preferences and best interests.
- ◆ Privacy issues are a concern, as many consumers are worried about (or have experienced) discrimination from the unauthorized disclosure of a mental illness or substance abuse problem. Older adults are often particularly concerned about stigma and the sharing of information.
- ◆ Consumers, particularly those with chronic conditions, can be overburdened financially and logistically if their care requires frequent appointments and multiple providers and treatments.



## SECTION TWO

### GENERAL DISCUSSION OF TOPICS AND RECOMMENDATIONS

#### **Fiscal Issues Drive the Context**

The panel set the stage for discussion by noting that, as medical costs have consistently outpaced the rate of general inflation and consumed an ever-larger portion of budgets, purchasers (whether employers, individuals or government) now insist that they have reached or exceeded their capacity to bear the costs of health care. In this environment, proposals for reform will be measured against their potential to either improve or worsen the current fiscal realities.

While some employers, particularly large employers, have piloted preventive approaches (e.g., wellness or employee-assistance programs) to stem rising health care costs, purchasers' most common response has been to limit their financial liability by requiring consumers to pay more. As a result, individuals must now shoulder a greater share of their health care costs. A reaction rather than a solution to burgeoning costs, this trend produces generally unsatisfactory outcomes: higher rates of un- or under-insurance as lower-wage workers drop coverage, more uncompensated care, and postponement or avoidance of medically necessary care by people who cannot afford increased co-payments or co-insurance.

At this juncture, cost-containing strategies that enjoy broad support among consumers, providers, policymakers and purchasers are those aimed at improving the quality of care and achieving administrative efficiency. Care integration has universal appeal by promising both to temper expenditure growth and to obtain better value for health care spending.

#### **Collaboration Is Needed to Make the Case for Integration**

Interest in the integration of health and behavioral health care has been mounting. Numerous reports in the

last decade—from the Surgeon General, the Institutes of Medicine, the National Mental Health and Substance Abuse Services Administration (SAMHSA) and the President's New Freedom Commission on Mental Health, among others—have cited as problems the fragmentation of care and the enormous cost of untreated behavioral health conditions. Although by no means a new idea, integration seems to be gaining ground as a growing body

of evidence shows positive outcomes. The studies suggest that it is cost-effective, produces improved clinical outcomes and is more satisfying for patients and providers alike. Findings like these underscore the need to integrate services.

While research supports the case for integration, the panel noted that the evidence must be more effectively organized and presented in ways that will resonate with various stakeholder

groups. To enlist employers, for example, information should be framed to show how fragmented care and untreated or ineffectively treated behavioral health problems affect workers' productivity and employers' bottom lines. Employers who see data showing the high costs of absenteeism, disability and health care coverage due to behavioral health disorders are more likely to understand their strong interest in promoting mental health and substance abuse parity.

In this arena, no single lever is expected to radically transform a mostly fragmented system into one that is integrated. Changing practices will take time, and progress will occur incrementally. What will help to hasten the transformation is collaboration among stakeholder groups, with recognition that each has a role to play. Historically, stakeholders have been quick to assign blame to other parties for failings in our health care system. Our panel members, however, recommended a collaborative

**Care integration has universal appeal by promising both to temper expenditure growth and to obtain better value for health care spending.**



approach in recognition of a shared interest in resolving problems in health care financing and delivery and in creating incentives that give all parties a stake in reaching toward the goal of integration.

### **Key Characteristics of Integrated Practices**

Some integrated care practices have bridged the gap between behavioral health and primary care. Examples include large co-located multispecialty group practices, community-governed nonprofit health centers and traditional private primary care offices.

Despite the differences in practice type and structure, our panel (which included primary care physicians with collective experience, either now or formerly, in a variety of practice settings) identified some common characteristics of successful integrated practices:

- a team approach,
- strong clinical and practice-management leadership,
- informal knowledge exchange,
- effective use of mid-level practitioners,
- a loyal base of consumers, and
- the ability to serve patients with complicated problems and diverse cultural and socioeconomic backgrounds.

The panel noted that staff in these practices is selected (and self-select) based on a commitment to working as part of an integrated team that views behavioral health as inseparable from health.

Good practice management ensures effective use of all staff involved in clinical care. In these practices, mid-level practitioners and allied health professionals are effectively deployed, allowing physician time to be effectively triaged. Scheduling and time-management problems are reduced when workloads are shared and staff can cover for each other when necessary.

Individual providers bring different expertise, skills, interests and talents to the team, and patients with complex medical and behavioral health needs benefit from the

team's collective knowledge and abilities. Furthermore, a team approach sharpens providers' skills in a way that solo practice cannot. Practitioners who have been in collaborative settings cite the informal knowledge exchange that occurs as even more important than formal continuing education and professional-development activities focused on improving care integration.

Because of the differences in philosophy and orientation, it is easy to see that, over time, practices with an integrative approach will attract clients who value integration. Word of mouth brings them new patients with challenging medical and behavioral health histories, and their practitioners in turn become more adept at identifying and treating complex problems and multiple conditions. Consumers develop confidence in their providers and the doctor/patient relationships are likely to endure longer than average.

In addition to being valued by consumers, this continuity of care is associated with lower costs because redundant tests and extended office visits are not needed when consumers are established with one primary care practice.

Committed to having the characteristics of a "learning organization," effective integrated practices seek feedback

mechanisms and information systems that allow them to appraise quality of care and delivery of services. This in turn creates an environment that is conducive to new learning and continuous quality improvement.

### **Growing New Integrated Practices**

Roundtable participants cited significant disparities among providers in their training, interest and ability to provide integrated services. While there was general consensus that integrated care should be seen as a professional standard of care, not simply an option, the panel favored a pragmatic, targeted (vs. blanket) approach. Rather than focusing on those most resistant to change, our panel felt that efforts and resources would be better

**Practitioners who have been in collaborative settings cite the informal knowledge exchange that occurs as even more important than formal continuing education and professional-development activities focused on improving care integration.**



applied to providers who express an interest in working toward integration.

If significant change is to occur in culture and practice, the group felt that it is likely to come incrementally, starting among providers who are receptive in attitude but who may require technical assistance and additional resources. Surveys have found a group of primary care providers who understand the imperative of integration but feel the need for help in improving their skills to identify and manage behavioral health problems. These practitioners seek practice guidelines, screening tools, decision support, professional relationships with specialty behavioral health providers, and guidance on practice management, reimbursement and other administrative issues. The panel felt that, if these needs are addressed, momentum would build toward a “tipping point” that, once reached, would result in a new professional norm that no longer tolerates fragmented care as an acceptable practice.

### **Parity in Coverage Is Critical**

It is important to consider the organization of health plans, contracting arrangements and benefit design because these features can either structurally impair or promote progress toward integration. Chief among our panelists’ concerns was lack of parity in coverage for mental health and substance abuse compared to other kinds of health care. Insurance products that do not have parity deter patients from seeking care at all or from seeking a particular treatment that is recommended.

### **Carve-Outs Discourage Integration of Care**

Roundtable participants also urged purchasers and health plans to eliminate private-sector behavioral health carve-outs that produce greater fragmentation in the system. Unifying the medical/surgical and behavioral health budgets will eliminate the additional administrative costs of a carve-out, while providing clear accountability and the financial incentive to treat behavioral health prob-

lems on a par with other medical conditions. As long as financial incentives exist for health plans and their subcontracting managed behavioral health care organizations to try to shift costs and responsibilities to the other entity, decisions will be based on a self-interest that may run counter to good medical care.

### **Continuity of Care Is Important**

Roundtable participants also urged managed care plans to reconsider the practice of having exclusive provider panels. While plans may be able to negotiate lower fees from physicians when panels are exclusive and there is competition to be part of the plan, problems arise with continuity of care when employers change insurers. Health plan enrollees must then find new primary care physicians or incur higher cost-sharing if their provider is not a part of the plan’s network. Continuity-of-care problems are not only disheartening to consumers, they also carry significant clinical and financial costs.

In addition to recommending changes to insurer practices, our panelists noted that purchasers should exert their influence by seeking out plans that provide parity, have unified medical/surgical/behavioral health budgets, and have provider panels that allow subscribers to have long-term relationships with their providers.

### **Reimbursement Practices Need to Change**

Noting that current reimbursement policies discourage integrated care, the panel deemed it important to ensure that the payment system works to support integration. For example, the current fee-for-service system rewards treatment of presenting problems singly rather than in a more comprehensive fashion by increasing the number of billable encounters and reducing the length of office visits. Providers who attract clients with complicated health histories (and who attract these clients precisely because of their integrated care practice) fare

**It is important to consider the organization of health plans, contracting arrangements and benefit design because these features can either structurally impair or promote progress toward integration.**



less well financially because they can see fewer patients in the same time period—e.g., a 30-minute office visit will not produce the same revenue as two 15-minute ones. Whether in fee-for-service or capitated arrangements, providers currently have an incentive to attract more patients with simple medical needs. A clear recommendation for health plans is to evaluate reimbursement policies to avoid such perverse disincentives to integrated care and to serving those most in need of care. (This was not a discussion about “gaming the system,” but rather recognition that these incentives and disincentives subtly affect practice.)

While it may appear that insurers have an interest in discouraging lengthy office visits, these reimbursement policies may lead to multiple visits by individuals with multiple complaints—an outcome that is neither cost-effective nor in patients’ best interests (with each visit, patients must take time out from school, work or family duties and incur extra travel expenses and additional co-payments). If patients are discouraged or unable to keep successive appointments, they will be more likely to incur expensive crisis services. Further, patients who feel that their providers have rushed through appointments and have not taken enough time to evaluate their health concerns are more likely to “doctor shop.”

Other problems relate to coding and documentation of treatment of behavioral health conditions in primary care. For example:

- ◆ Although Medicare will, not all insurers allow primary care providers to use CPT psychiatric codes.
- ◆ Codes that are used to describe a patient’s presenting symptoms, rather than a psychiatric diagnosis, can result in better reimbursement for the provider, creating a curious disincentive to report a diagnosis.
- ◆ Similarly, consumers in plans without mental health parity may avoid increased cost-sharing if the visit is coded for the symptoms, rather than the mental health diagnosis.

- ◆ Lack of standardization among payers and variability in coding and documentation policies add another level of complexity to the already complicated practice of medicine.

While code modifiers for evaluation and management (E/M) seek to address the extra time providers may spend counseling or coordinating care, much more should be done to adjust reimbursement policies so that they reward quality and accountability. Our panelists recommended that all payers adopt coding policies that put behavioral health treatment on a par with other medical care and that stakeholder groups work together to address coding deficiencies and the lack of common policies and documentation requirements.

The panel also recommended that health plans pilot projects that experiment with enhanced reimbursement for integrated care practices. In the public sector, some state Medicaid programs use a primary care case management approach, building into their reimbursement system performance expectations for providers and a monthly care management fee for each Medicaid re-

recipient enrolled in their practice. While this approach has also appeared in the private-sector managed care market, physicians have remained somewhat skeptical because their experience is that the third-party reimbursement system generally does not keep pace with the rising costs of running a medical practice. As pressure mounts for integration of care, it is useful to keep in mind that resistance to the idea is, at least in part, fueled by the perspective of providers who feel that they are continually being asked to do more for less compensation.

Rather than simply responding to approaches that come from payers, a task force of the American Academy of Family Physicians (AAFP), in the November/December 2004 issue of the *Annals of Family Medicine*, presented its model for rewarding physicians who provided a “medical home.”<sup>1</sup> An analysis of the model conducted by the Lewin Group, a health research consulting firm, posited that physicians who met the standards set forth in the

**Physicians who...  
provided a “medical  
home” ...could see their  
earnings rise 26% or  
more, while overall  
health-care expenditures  
for their patients would  
drop.**



model could see their earnings rise 26% or more, while overall health-care expenditures for their patients would drop. Expected savings would come from aggressive chronic-care management and efficiencies like electronic health records, e-mail communications and consultations, online appointments and practice-management innovations. The AAPF is seeking funding from insurers to develop a national demonstration project involving 10 to 20 practices.

Panelists cited insufficient recognition in the reimbursement system of the value of primary care and the degree of difficulty involved in providing integrated services. In contrast, under the current system, specialist services are heavily valued. Recognizing Medicare's historic role in shaping reimbursement methodologies, our panel expressed the need for re-evaluation of the values assigned to primary care, given that these values are reflected not just in Medicare but also in the private sector. Additionally, federal policymakers should authorize demonstration projects that seek to remove disincentives and appropriately weight the value of integrated care. The recent emphasis in Medicare law to encourage chronic-care demonstration projects is an opportunity that could be a vehicle for this kind of experimentation.

The panel noted that even with current reimbursement practices, not all primary care providers understand how to use behavioral health billing codes or how to obtain compensation for more complicated office visits. To ensure that reimbursement policies are fully understood, health plans, along with medical educators and professional societies, should provide guidance through continuing education programs and the development of written advisory materials.

### **Provider Practices Must Also Improve**

Roundtable panelists noted that more research is needed in methods for improving clinical practice and to ensure that the cycle of translating science into service is accomplished without undue delay. It is evident that the mere promulgation of best-practice guidelines does not

result in system-wide changes to clinical practice. Despite the advancement of scientific knowledge of behavioral health conditions, some practitioners, for example, still fail to recognize that head injuries may be responsible for some behavioral disorders. Others cling to outdated views, such as the myths that children do not suffer from depression and that attention deficit hyperactivity disorder (ADHD) is merely a parenting problem.

Changing clinical practice requires thoughtful strategies. The panel pointed out that, to be successful, continuing education and quality-improvement programs must be carefully tailored and targeted, since a cacophony of information will only stymie progress. In keeping with the research about "what works," any intervention to change culture and practice will require realistic expectations. Policymakers should recognize the multiple demands on providers' time—clinical care, practice management, continuing education and participation in various quality assurance/quality improvement projects at the behest of government, health plans and quality-assurance organizations.

Freeing up providers' time so that they can focus on learning and implementing new skill sets is critical to changing the culture. Our panel noted that it would be beneficial for those who initiate quality of care initiatives—including hospitals, private and public health plan administrators, and professional societies—to coordinate efforts and standardize procedures so that providers are not pulled in too many directions at once. For example, inroads have been made in achieving better care through increased reliance on best-practice guidelines for expensive chronic diseases like diabetes and asthma, since a number of payers are concurrently focused on quality-improvement efforts for these conditions. Similar efforts have been piloted for depression and ADHD.

### **Collaborative Approaches to Change Work Best**

To maximize the effectiveness and efficiency of practice-improvement programs, states could take the lead and coordinate efforts among various stakeholders

**Freeing up providers' time so that they can focus on learning and implementing new skill sets is critical to changing the culture.**



(both private and public) to develop common objectives, a shared implementation plan and a method of allocating shared costs. This approach would improve the likelihood that these efforts will actually improve the quality of care.

Clinical-learning collaboratives, a quality-improvement model widely used for diabetes, asthma and depression care, have been effective in promoting best practices. Roundtable panelists suggested that this model could be used to improve care for other frequently encountered behavioral health problems, including generalized anxiety disorders, obsessive compulsive disorders, addictive disorders and bi-polar conditions. Clinical collaboratives rely on interactive workshops and activity periods between workshops, using a stepped approach of small and manageable PDSA (Plan, Do, Study, Act) cycles.

Elements critical to the success of these collaboratives—to be kept in mind for other efforts—include:

- ◆ They are respectful of physicians' time and provide positive support rather than emphasizing failure.
- ◆ They target learning to evidence-based practices that have significant payoffs in health improvement, reinforcing the understanding that this is time well spent.
- ◆ They contribute to a culture of collaboration and continuous quality improvement.
- ◆ Indicators and data-collection efforts are standardized so that all stakeholders have confidence in the outcomes that are tracked.

### **Targeted Screening Pays Off**

Panelists suggested a targeted approach to improve screening and identification of behavioral health disorders in primary care. While screening for mental, emotional and substance abuse problems should be standard in all well-child and well-adult primary care, focused efforts to improve screening rates should start with the populations most at risk. Better identification of mental

and substance abuse disorders in these populations will have the biggest payoff in measurements of quality and cost-savings. Therefore, providers could improve their practices simply by being more alert to behavioral health disorders in groups most at risk.

Numerous studies have correlated the number of physical complaints with increased risk for psychiatric illness. For example, 90 percent of people with six or more physical complaints will have a diagnosable psychiatric condition.<sup>2</sup> The relationship between somatic complaints and depression is particularly high, and physical symptoms, rather than emotional distress, are the reason a majority of these individuals seek help from their primary care provider. Once this correlation is fully appreciated, providers can train themselves to consider the need to assess behavioral health status. Frequent visits to primary care, thick charts, complaints for which no somatic cause can be determined, and frequent use of emergency room services are some rough rules of thumb that could help remind practitioners that underlying behavioral health issues may need evaluation.

### **Screening Is Essential and Can Be Simple**

Our panel noted that screening tools should be workable and need not involve a long list of questions. For example, a New Zealand study examined the utility of simply questioning individuals about whether they had been feeling “down, depressed or hopeless” and/or had “little interest or pleasure in doing things.” The study concluded that this approach to depression screening was quite effective in sorting out which patients would require further evaluation.<sup>3</sup>

Panelists noted that patients with substance abuse problems are best identified when seen in primary care through regular screening in combination with provider recognition of “red flags”—physical and mental health signs and symptoms frequently found in people diagnosed with a substance abuse disorder. A popular tool among family practice physicians is the CAGE question-

**Better identification of mental and substance abuse disorders in the populations most at risk will have the biggest payoff in measurements of quality and cost-savings.**



naire. (CAGE is a mnemonic device for a questionnaire that asks about attempts to **C**ut down on drinking/drug use, **A**nnoyance with criticisms about drinking/drug use, **G**uilt about drinking/drug use and using alcohol/drugs as an **E**ye opener.)

Instruments like the CAGE questionnaire are not unwieldy and can help providers determine which patients will need a more detailed evaluation. If problem alcohol and substance use is detected, even brief physician advice and intervention can be helpful, although some individuals will require referrals to addiction specialists. The identification of substance abuse is important not only because of the disorder's prevalence and its relation to a host of medical problems, but also because it is very difficult to treat mental illness when substance abuse goes undetected.

There are a number of patient self-assessments (and screening questionnaires for parents of young children) designed to alert providers to potential behavioral health and developmental problems. In addition to tools used in medical offices, insurers, employers or consumer assistance programs can offer screening instruments and web-based questionnaires. These tools help consumers self-identify problems that should be brought to their health care provider's attention; they are generally accompanied by easy access to behavioral health information, referrals and online or phone interactions with behavioral health personnel.

Panelists noted, however, that self-assessments and internet tools only work for relatively sophisticated consumers who have computer skills and the motivation to become more involved in their health care. Verbal or written questionnaires will not work with some patients with depression, for example, who may not identify any problems with mood or cognition but rather with only somatic symptoms. An alert clinician may suspect depression, but the clues will not come from positive responses to questions about psychological well-being.

Other factors that determine whether patients will be able to express concerns about behavioral health issues include the stigma attached to mental health and substance abuse disorders, cultural and religious biases, coping styles, self-reflective abilities and exposure to psychological concepts. Further, clinicians must be aware that some patients may have had unsatisfactory experiences when their somatic complaints were not properly evaluated but rather were cursorily dismissed as "all in your head." These wary consumers may have good reason to resist talking about their behavioral health concerns for fear that this experience will be repeated.

### **Screening Should Be Universal**

In addition to making behavioral health screening a regular part of well-adult and well-child care, providers must take advantage of opportunities as they arise. For example, a pediatrician who may notice signs of maternal depression when seeing a child should not ignore the mother's potential needs and should explore whether further assessment and referral are necessary.

Because timely identification of and early intervention in behavioral health disorders are important, our panel noted that the screening imperative should extend not just to primary care providers but also to other medical specialists. Concerted efforts to identify behavioral health problems in patients who frequent emergency rooms and specialists' practices could have a great impact on quality and costs. These pro-

viders should not simply assume that behavioral health screening will be addressed in primary care. This would ignore the reality that many providers do not routinely screen for mental and substance abuse disorders, that many patients may not have a regular source of primary care, and that adverse outcomes may result from a delay in care because patients may not return to their primary care providers for a long time.

Broadly expanding the universe of providers with the knowledge and skills to effectively screen and address

**Concerted efforts to identify behavioral health problems in patients who frequent emergency rooms and specialists' practices could have a great impact on quality and costs.**

behavioral health issues will take time. There is a great need for cross-disciplinary communications and problem-solving among stakeholders. Health plans, hospitals, professional societies, quality-assurance entities and state health plan administrators could effectively be organized into working groups to develop a common set of objectives and to develop and initiate implementation plans.

### **Providers and Consumers Need Education on Screening**

To improve behavioral health screening rates, it is important to consider the factors that providers identify as discouraging them. These include inexperience in talking with patients about behavioral health issues, lack of knowledge about screening tools, and uncertainty about where to turn for decision support and guidance on practice management, reimbursement and other administrative issues. For example, if providers are reluctant to screen because they believe they may not be able to find a timely and appropriate referral for those they identify, then a stakeholder group (medical community, insurers, purchasers, policymakers and behavioral health advocates) may need to problem-solve this issue first—e.g., by identifying existing resources and sharing this information with providers, developing contingency plans when providers are in short supply and developing strategies to eliminate or mitigate resource limitations.

To address the lack of experience with screening tools, some health plans, professional societies and public health agencies have developed and disseminated screening toolkits. Comprehensive efforts are also already underway, like the Bright Futures initiative of the American Academy of Pediatrics (AAP), which has systematically set about changing pediatric practices to ensure that developmental and behavioral health status is an integral part of primary care for children. Bright Futures includes guidelines, a detailed framework for health professionals and a plan for implementation that is promoted through AAP chapters across

the country.

Skeptical providers may need help from peers who have overcome the challenges of changing clinical practices. Our panel suggested that those who have successfully incorporated regular screening in their practices could provide leadership, helping others overcome difficulties related to practice management or clinical care. Health plans also can ease the way by having a call line to assist clinicians who are looking for behavioral specialist referrals or consultations.

Other approaches to better identification of behavioral health problems are directed to consumers. Health plans and consumer-assistance programs have piloted consumer-education efforts, providing educational materials, self-assessment tools and referral services online or through printed materials and telephone consumer-assistance providers. These efforts are designed to encourage consumers to seek appropriate services and to help them problem-solve and better manage their own health care.

### **To Improve Treatment: Engage Consumers**

Our panelists suggested that good patient care requires clinicians not only to initiate effective treatment, but also to engage their patients and make sure there is understanding of treatment recommendations and appropriate follow-up. Treatment outcomes are too often diminished and health care resources wasted by a failure to follow through. For example, while the evidence supports the efficacy of antidepressants in combination with psychotherapy for the treatment of depression, neither the drug treatment nor the counseling is efficacious when prematurely discontinued.

Lack of follow-up is a problem clearly identified by recent research, showing that among patients for whom antidepressants are prescribed, 40 percent discontinue within a month and only 25 percent receive a follow-up appointment. Similarly, of those starting psychotherapy, 25 percent have only one session, with only half having four or more encounters.<sup>4</sup> These

**Good patient care requires clinicians...to engage their patients and make sure there is understanding of treatment recommendations and appropriate follow-up.**



statistics suggest that providers must do more than just initiate or refer for treatment. The primary care provider must discuss the importance of an adequate trial and have a realistic plan for follow-up.

Understanding the importance of enlisting consumers to self-manage their conditions and contribute to the efficacy of their care, our panel suggested that providers must know how to engage consumers effectively. Patients often have a difficult time absorbing all the information provided at the time of a visit, whether because of rushed office visits, medical jargon, poor doctor/patient communications, emotional distress or simply the difficulty of absorbing a lot of new information all at once. Since care can be useless if patients do not understand the professional advice and treatment plan, providers must assume some responsibility for assuring that the information is understood and remembered. A number of suggestions were offered to help facilitate patient knowledge.

For those with new diagnoses and treatment plans, it may be effective for clinicians to suggest, if the person is willing and there are no contraindications, that the patient bring a family member or trusted friend along to the office visit, recognizing that the other person can be another “ear” in addition to being supportive at home. As much as possible providers should back up oral communications with written handouts and instructions. It is also useful for physicians to use other members of the care team (nurse, nurse practitioner, physician assistant, social worker or health educator) to review and discuss the information with patients again. Since patients have different needs, learning styles and abilities, the clinician must tailor the information appropriately.

If an individual’s ability to take time off from work is limited or if co-payments are a barrier to compliance with follow-up appointments, these issues need to be addressed. Otherwise they are likely to derail any treatment plan. Recent studies have found telephone follow-up for medication—even telephone psychotherapy—effective in improving follow-through for depression treatment, but

again, payers will have to change reimbursement policy for telephone interventions if these are not currently reimbursed.

### **To Improve Treatment: Enlist Employers**

One of the ways large employers can help mitigate some of the logistical problems is to offer selected basic health care services (e.g., blood pressure monitoring,

blood draws for lab work, short interviews or check-in with patients to assess if a treatment plan is tolerated and progressing) in the workplace. With good coordination and communication between the on-site provider and the primary care physician, these workplace solutions can make it easier for employees to meet their work responsibilities while complying with their treatment plan.

Employers have ample motivation to assist in these efforts, particularly in the area of improved behavioral health care, since untreated depression and other behavioral health disorders account for significant losses in productivity.

### **To Improve Treatment: Coordinate Care**

Many health plans offer case management and other ancillary services. Employee-assistance programs have entered this arena as well, offering care coordination and supportive services to people with chronic health care needs. Assistance may be offered online, by phone and through personal contact. In many integrated practices (like community health centers and other primary care practices that have the characteristics of a community health centers, as well as large multi-specialty group practices, like a staff model HMO), staff members on site assist individuals with care coordination and social services in overcoming any barriers to person’s ability to follow through with treatment. Patients and providers who have experience with on-site care management staff are enthusiastic about the benefits and seem to prefer this model to one in which care is coordinated by another party and services are provided at different locations.

Our panelists recommended that insurers fund dem-

**With good coordination and communication... workplace solutions can make it easier for employees to meet their work responsibilities while complying with their treatment plan.**

onstration projects, offering providers financial incentives to develop care-coordination capacity within their practices. These projects could be initiated in practices that serve a high proportion of people with chronic diseases and behavioral health disorders. Public and private payers, for example, could jointly share the cost of care management staff. In helping vulnerable populations navigate a very complex system, the health plans can expect some payoff from eliminating duplicative or wasteful services, while optimizing consumers' opportunities for clinical improvement and recovery.

Another approach is for health plans to foster care management by reimbursing it on a fee-for-service basis or by providing monthly case management fees on a per capita basis. Monthly fees help providers cover the costs of important transactions that are necessary to good patient care but currently don't have a reimbursement mechanism. Particularly for patients with multiple problems and conditions, providers may spend significant time consulting with other health care and social services providers, pharmacists and case managers without any mechanism for reimbursement.

By not compensating for this time, the system again provides perverse incentives. Providers are effectively discouraged from serving high-needs populations and engaging in professional collaboration. While a blanket monthly fee could cover a range of services, other specific services, like phone consultations with specialists, could be established as reimbursable services with separate billing codes. Although no one expects the office visit to be replaced by telephone or video interactions, increasingly these are becoming components of good patient care and, consequently, are worth reimbursing.

### **To Improve Treatment: Disease Management**

As our panelists suggested many times, resources should be targeted to opportunities for large payoffs. Both private and public purchasers of health care coverage have reached this understanding. As a result, they

continue to fund and expand disease-management initiatives with the potential to improve health care quality, manage costs and achieve better consumer outcomes. With funding in the new Medicare Modernization Act for disease management initiatives, it was suggested that the time is especially ripe for public/private collaborations.

While much attention has been paid to diseases like diabetes, heart disease and asthma, disease-management approaches are also in current use for depression, anxiety and other common psychiatric disorders. Essential components of such initiatives include evidence-based practice guidelines, collaborative practice models that include clinical and support-services providers, patient self-management education, process and outcome measures, evaluation, reporting processes, and a mechanism to provide feedback to clinicians.

In accumulating experience with disease-management, purchasers and health plans are increasingly realizing how reimbursement mechanisms may impede these worthwhile efforts. "Paying for performance" is one response to changing the dynamic in the reimbursement system so that quality objectives are rewarded rather than discouraged. Under the pay-for-performance approach, financial incentives are used to encourage adherence to best practices and to reward innovations that improve health outcomes. If a health plan's reviews, for example, find that a provider has followed best-practice guidelines or a disease-management program, the provider would receive a bonus or enhanced reimbursement.

Support for pay-for-performance initiatives have come from various stakeholders. The National Business Coalition on Health (NBCH), for example, launched "Bridges to Excellence" (BTE), a physician-incentive program that focuses on practice guidelines and evidence-based treatment, as well as technological and practice-management improvements that support quality and efficiency. NBCH recognizes that employers have a stake

**Although no one expects the office visit to be replaced by telephone or video interactions, increasingly these are becoming components of good patient care and, consequently, are worth reimbursing.**



in improving physician performance because it can both lower direct health care costs for their employees and reduce productivity losses due to impaired health status. The Leapfrog Group and the Integrated Healthcare Association (IHA) also have pay-for-performance initiatives, with Leapfrog focusing on hospital performance and IHA focusing on rewarding excellence through contracting with physician groups. IHA and Bridges to Excellence are part of the \$8.8 million Rewarding Results program, a collaborative partnership that receives funding from the Robert Wood Johnson Foundation (RWJF), the California Healthcare Foundation, and the Commonwealth Fund.

### **To Improve Treatment: Medication Management**

Panelists were acutely aware of the need to focus on improving prescribing practices and medication management. They recognized that providers face a number of daunting challenges—e.g.: increasing complexity in treatment options, given the rapid introduction of new drugs (more and different types of drugs, some with significant therapeutic benefits and others offering little or no advantage over older drugs); increased patient demand for drugs fueled by direct-to-consumer advertising; and increasing questions about the validity of pharmaceutical industry-sponsored research and misleading presentations in journal articles. The issue is of enormous interest to health plans and purchasers, since pharmacy spending continues to rise about 15 percent per year. Many health plans and purchasers, including Medicaid, are ramping up efforts to provide decision support and to monitor and improve providers' prescribing practices through educational efforts, practice guidelines, physician profiling, peer-to-peer feedback and pharmacist consultations.

### **To Improve Collaboration: Flexible Approaches to Co-Location**

While some primary care physicians and psychologists may still believe that virtually all behavioral health

treatment belongs in the domain of mental health professionals, this view simply ignores the reality of current patterns of care. Citing a 1980s Epidemiologic Catchment Area (ECA) Study, a subcommittee of the New Freedom Commission on Mental Health reported that “about half of the care for common mental disorders was delivered in general medical settings.”<sup>5</sup>

A number of factors have contributed to this reliance on primary care, including:

- health coverage that places greater limitations and higher cost-sharing requirements on behavioral health specialty care, thus discouraging individuals from accepting behavioral health referrals;
- increased use of psychiatric drugs and short-term interventions and less reliance on long-term psychoanalysis and psychotherapy;
- consumer preferences—patients generally prefer to receive mental health counseling and treatment within their primary care setting; and
- widespread behavioral health provider shortages.

As a result of these and other factors, both primary care and behavioral health providers are increasingly aware that most patients will rely on primary care for treatment of their behavioral health conditions. With the understanding that only a small percentage of patients referred to behavioral health providers will actually follow through with appointments, some behavioral health professionals have begun to re-think their roles and practice arrangements. A growing number of psychiatrists, for example, serve as consultants for other providers. Some have found ways to be part of a team approach even if they cannot be co-located. In this model,

for example, a child psychiatrist may travel to primary care offices, schools and other settings, providing on-site consultations and direct care. An accommodation borne of necessity, particularly in rural areas or when subspecialists (like child and geriatric psychiatrists) are in short supply, this new paradigm has its merits, even without provider shortages as an issue, in that it promotes a cul-

**Most consumers appreciate “one-stop shopping” and the knowledge that their providers are collaborating on their health care in a comprehensive way.**

ture of interdisciplinary training, knowledge exchange and collaborative care.

Most consumers appreciate “one-stop shopping” and the knowledge that their providers are collaborating on their health care in a comprehensive way. Psychiatrists participating in these new practice arrangements are positive about this evolution, recognizing that they can accomplish more than under the old paradigm. Roundtable panelists felt that the approach of bringing specialists into primary care practices was especially promising and saw added value in co-location, even if the specialists were only there on a part-time basis.

Other behavioral health practitioners may choose to co-locate or join a primary care practice, providing both direct care and consultation services on a permanent basis. Generally these integrated practices—whether a private group practice or a community health center—incorporate regular social work and/or psychological services on-site, while individuals with more specialized needs will continue to be referred out.

Another model that has been tried in a limited number of places is the combined community mental health center and community health center, offering a full range of both primary care and behavioral health services. While there is growing interest in this model, it is primarily seen as a public-sector model for delivering services to underserved and vulnerable populations. In the private sector, a large group practice, like a staff-model health maintenance organization, for example, may have some similar features, providing a range of specialty mental health providers in one location along with primary care. However, in these large group practices, some of the advantages of co-location may be lost if the emphasis on collaboration and teamwork is not preserved through careful nurturing. For example, to ensure opportunities for informal interaction and collaboration, primary care and behavioral health providers could be placed in the

same suite of offices or in close physical proximity.

Models of co-location are currently more the exception than the rule, however, and other strategies are being employed to bring behavioral expertise into the primary care office. Many health plans employ behavioral health specialists to provide round-the-clock telephone consultation and decision support for primary care providers. Local medical communities, academic medical institutions or hospital/physician organizations have also responded to the need by promoting telephone or video consultations between primary care and behavioral health specialists. In rural areas or when specialists are otherwise unavailable in a community, interactive video technology may be employed to allow a specialist at a remote location to provide direct service to a patient during a visit to a primary care practitioner. These new arrangements, however, underscore the need for changes in reimbursement policies so that provider time is compensated when it occurs outside the traditional office visit.

**Behavioral health providers must also work to ensure that primary care health needs are met. They should urge regular screening and discuss primary care treatment goals and self-management issues, reinforcing the view that fragmented services are not good medical care.**

### **To Improve Collaboration: Share Information**

Regardless of the practice arrangements, providers will need to develop an understanding among themselves as to how they will communicate and collaborate on care, particularly when there is not a shared medical record. However, insurers, medical educators and professional societies, hospitals and public-sector health plans can assist by convening forums to discuss these issues and by developing standard processes and forms. Both primary care and specialty providers must educate consumers about the need for information to be shared with other professionals and routinely ask consumers to provide written authorization.

Finally, the discussion focused on recommendations of new roles for behavioral health specialists in the context of supporting integration in primary care. Behavioral health providers have a responsibility to counsel their

clients about the value of primary care and the high incidence of co-occurring medical and psychiatric disorders. They must foster collaboration and a team approach by asking clients to provide written consent to allow them to share information and consult with their primary care provider. Just as our panelists recommended that primary care clinicians have a professional obligation to provide both health and behavioral health care, behavioral health providers must also work to ensure that primary care health needs are met. They should urge regular screening and discuss primary care treatment goals and self-management issues, reinforcing the view that fragmented services are not good medical care.

### **Re-Tool to Support Integration**

The benefits of using information technology (IT) tools in health care are undeniable. Innovations like electronic medical records (EMRs), computerized drug-order entry and clinical decision-support systems can improve the quality of care patients receive and increase efficiencies in medical practice. But despite the clear benefits, health care organizations and physicians have been slow to embrace such technologies, due in large part to the high cost of implementation.<sup>6</sup>

Much attention has focused recently on providers' need to use more efficient and responsive information systems and to develop the capacity to collect and use data to support continuous quality improvement. While primary care offices have used computer billing and accounting systems for some time and, more recently, have developed the capacity to submit electronics claims, most office-based medical practices rely on paper systems for scheduling and patient records.

Even though there is always some reluctance to institute new technology, there is general agreement that

electronic medical records are an important component of improving medical practice. They promote efficiency, cut down on errors because records are more readable, help to sort and organize important medical information, make collaboration easier because records are accessible electronically, provide tracking systems for preventive services and follow-up care, and generate data to sup-

port quality improvement and accountability. Hand-held PDAs help providers track prescription histories and access prescribing information and health plan formularies—all critical information that can be time-consuming to track down if not available electronically in the exam room. The biggest barriers to adoption of these new technologies are staff training and the cost of hardware and software purchases.

Our panelists suggested that other stakeholders—e.g., health plans, employers and individual purchasers, and government entities—in addition to the providers themselves, need to recognize their interests in re-tooling medical practices and in financially and logistically supporting the conversion to electronic medical records, since the costs of implementation and training currently discourage widespread adoption.

**Electronic medical records...promote efficiency, cut down on errors because records are more readable, help to sort and organize important medical information, make collaboration easier because records are accessible electronically, provide tracking systems for preventive services and follow-up care, and generate data to support quality improvement and accountability.**

## SECTION THREE

### RECOMMENDATIONS

#### General Recommendations

- ✓ Make the case for integration, framing the issues and tailoring the message in ways that will best motivate individual stakeholders and stakeholder groups.
- ✓ Increase effectiveness of initiatives by collaborating with other stakeholders.
- ✓ Set realistic goals and timelines, because changing practices will take time and occur incrementally.
- ✓ Collaborate with others to support pilot projects and evaluation of these projects. Research findings should be widely shared so that a growing body of knowledge informs new efforts.
- ✓ Consider the results of untreated behavioral health disorders—not only effects on health care expenditures but also the costs of absenteeism, lost productivity and disability benefits.
- ✓ Initially, target resources to care-integration strategies that are likely to yield a good return on investment. Initiate efforts in each stakeholder category with those who are most interested in working toward change.
- ✓ Understand the power of success. As effective integration strategies multiply, these examples will breed new efforts and, over time, a tipping point will be reached.
- ✓ Collaborate with others to create incentives and eliminate disincentives so that the health care system supports rather than discourages integrated care.

#### Recommendations for Primary Care Providers

- ✓ Embrace integration as a professional norm.
- ✓ Engage in activities such as strategic planning and regular evaluation, as do other types of modern organizations. While patient care and keeping up with scientific developments are certainly prime responsibilities, providers cannot afford to ignore the business aspects of medicine, which clearly affect both access to services and quality of care. As they adapt

to changes in the evolving health care marketplace, primary care practices must also contribute to the development of solutions to some of the problems and perverse incentives in the market.

- ✓ Be willing to change. To develop a successful integrated practice, providers must cultivate team approaches to patient care, strong clinical and practice-management leadership, informal knowledge exchange among team members, and the ability to serve patients with complicated problems and diverse cultural and socioeconomic backgrounds.
- ✓ Commit to having the characteristics of a “learning organization.” Effective integrated practices must develop feedback mechanisms and information systems that allow them to appraise quality of care and delivery of services, creating an environment conducive to new learning and continuous quality improvement.
- ✓ Plan for integration. In developing and implementing a plan for their practices, organizations must address various needs, such as screening tools, decision support, methods for conferring and referring to behavioral health providers, etc.
- ✓ Take a leadership role in the medical community if you have an integrated practice. Urge stakeholders to address barriers to integration, participate in stakeholder work groups and offer to mentor others who are embarking on integration efforts.
- ✓ Establish behavioral health as integral to primary care practice, adding mental health and substance abuse screening into the periodicity schedule of well-adult and well-child care. While some primary care providers may not currently view this screening as a core component of primary and preventive care, the practice of medicine is evolving and it should be as integral as monitoring cardiovascular risk.
- ✓ Use efficient screening tools that leave time to address other health care needs. Simple two-question screens and patient self-assessments are useful in



helping to identify patients with behavioral health needs.

- ✓ Screen on a regular basis, but also be alert to incipient problems as new stressors emerge (e.g., serious illness, new baby, change or loss of employment, major illness or death of a family member, new spouse, divorce, child leaving home) or multiple, unexplained somatic complaints appear.
- ✓ Develop and implement plans to establish effective collaborative relationships with behavioral health specialists, incorporating into practices effective medication- and disease-management programs, patient education and self-management supports.
- ✓ Explore opportunities and different models for co-locating or bringing behavioral health practitioners into primary care.
- ✓ Ensure that consumers understand the nature of their conditions, treatment options and recommended follow-up care. Inquire about any barriers to follow through—e.g., unaffordable cost-sharing, an inability to take time off from work, transportation problems. As part of quality-improvement efforts, determine routine processes for identifying and resolving problems that may interfere with consumers' ability to follow through with treatment plans.
- ✓ Offer weekend and evening appointments so that consumers can meet work and school obligations. If follow-up appointments are difficult to arrange, considering supplementing less frequent office visits with telephone and e-mail follow-up.
- ✓ When appropriate, encourage consumers to bring a family member to an appointment.
- ✓ Back up oral communications with written handouts and instructions. Recognize that consumers have different learning styles and abilities and tailor information appropriately.
- ✓ Participate in behavioral health learning collaboratives and other continuing education activities to support integration of care.
- ✓ Incorporate electronic medical records and health information technology to improve the ability to collaborate and practice efficiently.

## **Recommendations for Health Plans**

- ✓ Use contracting arrangements and benefit design to support integration. Health plans should design insurance products that provide parity, have unified budgets (no carve-outs) and non-exclusive provider panels.
- ✓ In adjusting expectations and reimbursement schemes, do not ask providers to do more without realistically appraising the costs and providing sufficient reimbursement.
- ✓ Devise new methodologies for recognizing case-mix variation and reward integrated care through enhanced reimbursement. Reimburse providers for care management.
- ✓ Through collaboration with other stakeholders, experiment with reimbursement mechanisms by funding national demonstration projects that promote integrated care.
- ✓ Join with other public and private insurers, including Medicare and Medicaid to:
  1. Recalibrate compensation of primary care. Current reimbursement systems have generally been influenced by Medicare, which has historically undervalued primary and behavioral health care.
  2. Standardize and streamline payer processes, data collection, performance indicators and other documentation requirements.
  3. Reduce, where possible, administrative burdens so that providers can devote resources to caring for patients.
  4. Plan and implement shared quality-improvement initiatives.
  5. Promote research and implement programs (like clinical learning collaboratives) that have been shown effective in changing provider behavior to correspond to best practices.
  6. Help fund practices' conversion to electronic medical records.
- ✓ Give practitioners regular, data-driven feedback about their practices, adherence to professional guidelines and other information that will help them engage in their own continuous quality-improvement activities.

- ✓ Directly fund or reimburse for services provided by care managers and social workers in integrated health care practices. Invest in public/private pilot projects for funding these workers in practices that serve a higher proportion of people with chronic diseases and behavioral health disorders. Having care managers and social workers on site as members of the care team is particularly valuable, increasing the provider's capacity to deal with contingencies that arise in caring for individuals with a range of health care needs.
- ✓ Promote and provide incentives for primary care practices to adopt proven chronic-care and disease-management programs, focusing on effective behavioral health programs, such as Partners in Care (a depression-care management model). Promote similar efforts for other common behavioral health problems (e.g., ADHD, anxiety disorders, alcohol/substance abuse problems and obsessive compulsive disorder).
- ✓ Bolster treatment follow-through by purchasing case-management assistance and other ancillary services for people with chronic health care needs. Assistance may be offered on line, by phone and through personal contact.
- ✓ Provide reimbursement for services like telephone consultations, electronic patient/physician communications and care coordination, or devise alternative mechanisms to compensate providers fairly for their time.
- ✓ Provide plan-sponsored 24-hour consult lines, referral services and care coordination.

### **Recommendations for Employers as Purchasers of Health Care**

- ✓ Understand the full costs of untreated or ineffectively treated health and behavioral health conditions—not just health care costs, but effects on productivity, disability and workers compensation.
- ✓ Use your purchasing power to drive demand for insurance products that promote integration through benefit design (e.g., mental health and substance abuse parity), reimbursement mechanisms, contracting arrangements and performance requirements.

Ask what your health plan is doing to promote integration.

- ✓ Band with peers to use your aggregate power to influence the insurance market. Serve as a peer mentor to other, less experienced employers through informal and formal associations and share your experiences through case studies that highlight your successful efforts.
- ✓ Promote regular behavioral health screening by:
  - using purchasing power to obtain health plans that have behavioral health screening standards;
  - offering confidential screening in the workplace; and
  - funding employee assistance programs that promote screening and access to web-based screening programs and consumer education materials.
- ✓ Offer the convenience of making some basic health care services available in the workplace (e.g., blood pressure monitoring, blood draws for lab work, short interview or check-in with patients who are undergoing treatment to assess if their treatment plan is tolerated and progressing). With good communication between the on-site provider and the primary care physician, these workplace solutions can make it easier for employees to comply with their treatment plan while meeting their work responsibilities.
- ✓ Reinforce health care quality by adopting “pay for performance” approaches and by participating in associations and business coalitions that are focused on improving the quality and efficiency of health care services. Join stakeholder work groups.
- ✓ Research and develop appropriate strategies for small and medium-size employers. To date, large employers have undertaken most of the purchasing and employee assistance strategies.

### **Recommendations for Academic Institutions and Professional Societies**

- ✓ Medical school and residency programs should:
  - Emphasize integrated treatment approaches and effective behavioral health/primary care collaboration, and provide experience in working as part of an interdisciplinary team.



- Increase training for primary care providers on psychosocial issues and mental health and substance abuse disorders.
- Teach chronic-care and disease-management approaches for behavioral health disorders.
- Teach techniques for educating consumers and motivational strategies that will foster self-management skills.
- ✓ Professional societies should:
  - Develop peer-mentoring programs to help primary care providers with less experience in integrated practices.
  - Provide continuing education opportunities focused on care integration, behavioral health management approaches, and reimbursement, coding and other documentation issues.
  - Convene collaborative, cross-disciplinary meetings between behavioral health and primary care to address gaps in services and promote treatment protocols and adherence to evidence-based practices.
  - Tackle the factors that providers identify as discouraging them from starting integrated behavioral health, including inexperience in talking with patients about behavioral health issues, lack of knowledge about screening tools, and uncertainty about where to turn for decision-support and guidance on practice management, reimbursement and other administrative issues.
  - Initiate practice-improvement initiatives, peer teaching and mentoring, and cross-disciplinary work groups. For example, primary care and behavioral health providers could work with cardiologists, who may see individuals with panic disorders, or gastroenterologists, who may see patients with psychiatric conditions that manifest themselves in conditions like irritable bowel syndrome.
  - Promote and use research that shows which approaches are most effective in changing provider practices to correspond to practice guidelines.

## **Recommendations for State and Federal Policymakers**

- ✓ Convene stakeholder workgroups to identify federal and state laws and regulations that interfere with efforts to improve care integration. Change policies accordingly.
- ✓ Change Medicare reimbursement policies to favor integrated care, given that Medicare historically has had the most influence in establishing reimbursement methodologies.
- ✓ Use the Medicare Modernization Act to fund disease-management demonstration projects that focus on behavioral health conditions.
- ✓ Convene and lead collaborations with private insurers and accrediting organizations (such as NCOA and JCAHO) to develop clear performance standards for care integration.
- ✓ Allocate federal funds for government agencies (e.g., SAMHSA, AHRQ, NIMH, HRSA and the VA) to offer technical assistance helping health care providers to implement and disseminate evidence-based models for improving quality of care and care integration.
- ✓ Provide grants and other incentives to academic institutions to improve training of medical and behavioral health practitioners.
- ✓ Encourage providers to convert to electronic medical records and other health information technologies through grants and loans. Training funds should also be made available to ensure a smooth transition.
- ✓ State agencies—e.g., Medicaid, health, mental health and insurance: Convene stakeholder workgroups on various subjects, including the streamlining and standardization of requirements imposed on providers (e.g., pertaining to documentation, performance reporting and information management), quality assurance/improvement, reimbursement and administrative issues, health information technology, etc. These workgroups should include consumer representatives, health plans, hospitals, professional societies, medical educators, quality assurance entities, employers and state health plan administrators to develop a common set of objectives and develop and initiate implementation plans.

- ✓ Initiate public/private pilot projects to fund care managers and social workers in practices that serve a higher proportion of people with chronic diseases and behavioral health disorders.
- ✓ Convene public/private stakeholder groups that have an interest in addressing issues of complexity and cost in prescription drug treatment. Focus on collaborative efforts to monitor and improve prescribing practices through education, practice guidelines, physician profiling and peer-to-peer feedback
- ✓ Provide grants and seed money to encourage co-location of behavioral health practitioners in primary care practices.
- ✓ Revitalize public health agencies and restore effective programs like nurse home-visiting programs.

## CONCLUSION

In recognition that, now more than ever, inadequate health care squanders precious resources, we see a burgeoning interest in addressing the problems of care fragmentation. While more a daunting challenge than a clear opportunity, the problems of spiraling health care costs nonetheless provide powerful motivation for system change. Proponents of integration have new opportunities, given the mounting evidence correlating effective treatment of psychiatric conditions with overall reductions in health care costs. Indeed, the potential for cost-savings extends beyond health care expenditures. Numerous studies show that untreated mental illnesses and addictive disorders account for academic failure, losses in employee productivity and increased government spending on social services, corrections and juvenile justice.

While integration is a frequent topic in discussions about health care reform, it is hardly a new idea. Some of the skepticism that advocates for reform will encounter is doubtless based on prior attempts that failed to effect change. Widespread discouragement about health care reform in general, and the perception that changes during the last decade have worsened rather than improved the situation, are factors that cannot be ignored. And many view the realignment of financial incentives through

managed care in the 1990s both as having failed to contain costs and improve care and as contributing to new problems.

To ensure that the new interest in integration yields reform rather than failure, our panel stressed the importance of understanding why our fragmented system resists change. As in most reform efforts, resistance often

stems from stakeholders' fears of being worse off under a new paradigm. While realignment of financial incentives to achieve the policy objective of integration will undoubtedly produce different outcomes for different stakeholders, it is important to address these concerns systematically so that generalized fears about change do not derail efforts.

One way to avoid derailment is to use collaborative processes when developing new policies, giving each stakeholder group the opportunity to come in on the ground floor. With evidence supporting a common interest in promoting

integrated care, the challenge is to ensure that the details of implementation serve the desired objectives.

The panel also found ample opportunities for collaboration between the public and private sectors. For example, a provider who participates in a Medicaid best-prescribing-practices quality-improvement project will bring the knowledge thus gained to privately insured pa-

**Proponents of integration have new opportunities, given the mounting evidence correlating effective treatment of psychiatric conditions with overall reductions in health care costs.**



tients. Policymakers should work to bring the private and public sectors together to capitalize on these opportunities and remove unnecessary administrative burdens that take the focus away from quality of care.

It is worth noting that some trends currently operate on parallel tracks in both private and public-sector health plans. While the words may have different nuances, there is increased emphasis in both sectors on consumer education, self-management, recovery, person-centered care and consumer-directed services. We believe this trend suggests that the “medical model” and the “recovery model” can fruitfully converge in systems of care that provide effective, high-quality services, while meeting individual needs and achieving better value for health care spending.

Viewed in this context, it becomes clear that integration is more than just coordination of services or improved communication between providers. True integration requires a paradigm shift and new approaches to delivering health care.

Where the old paradigm assumed that behavioral health care was provided by separate panels of providers in separate locations, the new one recognizes that behavioral health care must be integrated with primary care. Accordingly, the debate now is not whether many individuals with behavioral health disorders will be treated in a primary care office, but rather how to ensure that they are appropriately treated in this setting.

It is our hope that, rather than being an endpoint, these recommendations will promote ongoing discussion and new initiatives to end the needless health disparities associated with uncoordinated care and the failure to provide integrated services.

## NOTES

<sup>1</sup> Spann, S., for the members of Task Force 6 and The Executive Editorial Team (2004). Report on Financing the New Model of Family Medicine. *Ann Fam Med*. 2004;2 (supple 3):S1-S21.

<sup>2</sup> Kroenke K. (2003). Patients presenting with somatic complaints: epidemiology, psychiatric comorbidity and management. *Int J Methods Psychiatr Res*. 2003;12(1):34-43; Katon, W, Walker E. Medically unexplained symptoms in primary care. *J Clin Psychiatry*. 1998;59(Suppl 20):15-21.

<sup>3</sup> Arrol, B. et al (2004) Screening for Depression in Primary Care with Two Verbally Asked Questions: Cross Sectional Study, *British Medical Journal* 327:144, November 15, 2003.)

<sup>4</sup> Simon, G. et al (2001). Treatment process and outcomes for managed care patients receiving new antidepressant prescriptions from psychiatrists and primary care physicians. *Arch Gen Psychiatry*. 201;58:395-401.

<sup>5</sup> An Outline for the Draft Report of the Subcommittee on Mental Health Interface with General Medicine (2003), [http://www.mentalhealthcommission.gov/subcommittee/MHIInterface\\_010803.doc](http://www.mentalhealthcommission.gov/subcommittee/MHIInterface_010803.doc), accessed 11/04/04.

<sup>6</sup> Audet, A. et al (2004). Information technologies: When will they make it into physicians' black bags? *Medscape General Medicine* 6(4). Accessed 12/8/04 at [http://www.medscape.com/viewarticle/493210\\_print](http://www.medscape.com/viewarticle/493210_print).

# PARTICIPANTS

## Roundtable on Integrating Physical and Mental Health Services to Improve Care for People with Mental Illnesses September 13-14, 2004 Washington, DC

Rhonda Robinson Beale, MD  
Chief Medical Officer  
CIGNA Behavioral Health  
Eden Prairie, MN

Robert Berenson, MD  
Senior Fellow  
The Urban Institute  
Washington, DC

Scott Bernard, MBA, MPH, PhD  
Vice President  
ValueOptions  
Troy, NY

Virginia Trotter Betts  
Commissioner  
Department of Mental Health and Developmental  
Disabilities  
Nashville, TN

David Fassler, M.D.  
Clinical Director, Otter Creek Associates  
Burlington, VT

Andrea Gelzer, MD  
Vice President for Clinical Affairs, CIGNA HealthCare  
Hartford, CT

Annette Hanson, MD, MBA,  
Consultant  
ValueOptions  
Newton, MA

Deborah Lee, Ph.D.  
Project Coordinator  
RWJ Depression in Primary Care Program  
University of California, San Francisco  
Division of General Internal Medicine

Saul Levin, MD, MPA  
President  
Access Consulting International, Inc.  
Washington, DC

John D. Matthew, MD  
Director  
The Health Center  
Plainfield, VT

### **Bazelon Center Staff**

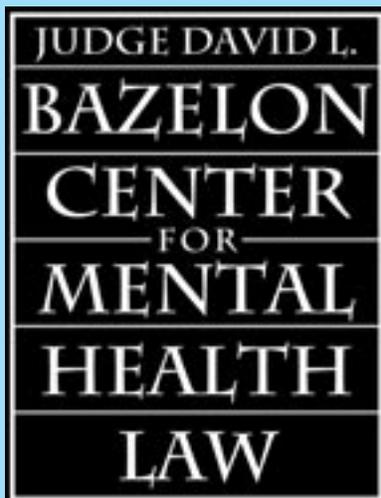
Robert Bernstein, Ph.D.  
Executive Director

Chris Koyanagi  
Policy Director

Elaine Alfano  
Policy Analyst



BAZELON CENTER FOR MENTAL HEALTH LAW  
1101 Fifteenth Street NW, Suite 1212  
Washington DC 20005  
202-467-5730  
fax 202-223-0409  
pubs@bazelon.org  
www.bazelon.org



JUDGE DAVID L.

BAZELON

CENTER

FOR

MENTAL

HEALTH

LAW