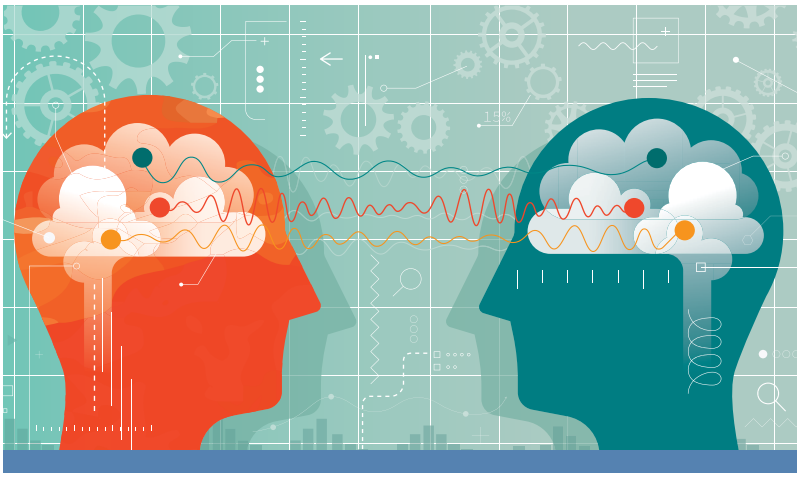
SECTION 3

Interventions with potential to improve behavioral health

During the planning and discovery stages of the project, we heard challenges that members faced in accessing behavioral health care. We explored concerns CHCC member plans expressed about, safety, and effectiveness of behavioral health care received by plan members. We looked for practical, community-oriented solutions that may improve access, patient-centeredness, and outcomes for common behavioral health conditions. We focused on solutions that could be implemented in the medium term, particularly if purchasers collaborate to request similar solutions from health plan and provider entities.



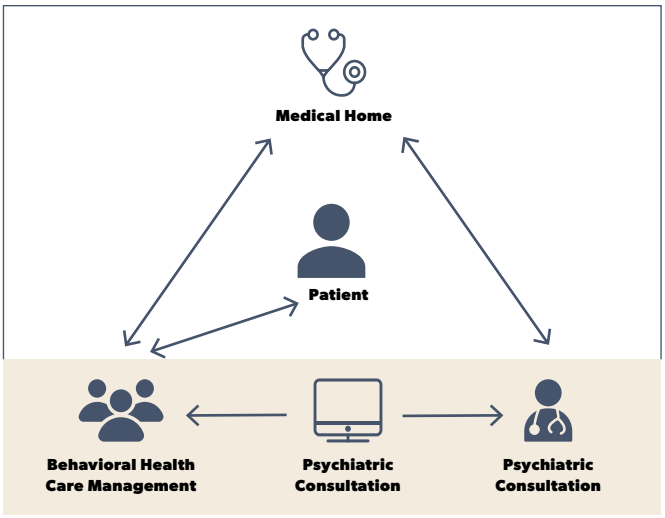
1. Behavioral health integration and collaborative care

With an estimated one in five U.S. adults living with a mental health condition, patients commonly present symptoms in primary care. Three-quarters of anti-depressants are prescribed by primary care clinicians. Some estimates suggest that 20% of primary care visits relate to mental health, yet many patients are not accurately diagnosed in primary care, due to time, training, and coverage constraints. There is an even bigger shortage of specialized behavioral health care in pediatrics compared with adults.

Patient outcomes can improve when primary care and behavioral health clinicians use a collaborative system of care, but integrating these services is challenging. Structural factors in primary care, such as bigger patient panels and shorter patient visits, are worsened by fee-for-service volume incentives and time burdens of preauthorization requests, billing and electronic medical record entry. Primary care practices are under-resourced. Many patients must access a behavioral health organization or network of providers (i.e., a “carve out”) separate from their plan’s medical benefits payer. This complexity can delay behavioral health referrals made in primary care and contribute to primary care clinicians’ reluctance to ask patients about behavioral health. Despite barriers in implementing behavioral health integration, research suggests a return on investment in the form of both better outcomes and lower overall system costs.

Evidence for BHI for populations, conditions

Models of behavioral health integration have been tested and evaluated and most have found improvements in mental health outcomes and medical outcomes of chronic disease in patients who have multiple conditions. The Psychiatric Collaborative Care Model (CoCM) was developed at the University of Washington in the 1990s and has been tested in randomized trials in many settings. The CoCM model embeds a consulting psychiatrist and behavioral health manager into primary care to support primary care clinicians to manage mild to moderate behavioral health issues. The physician prescribes while others on the team manage a patient registry, track care and symptoms, counsel patients, and advise the physician.



Source: The AIMS Center at the University of Washington

PCORI supported a study that randomly assigned patients who had screened positive for depression, post-traumatic stress disorder, bipolar disorder or both to two different tele-psychiatry interventions, tele-psychiatry collaborative care (TCC) and tele-psychiatry enhanced referral (TER). In the TCC model, care managers and consulting psychiatrists supported the primary care practice. In the TER model, tele-psychiatrists and tele-psychologists assumed responsibility for treatment typically provided virtually to patients at the primary care clinic. Both models improved outcomes by similar rates, including symptom severity, care satisfaction, and medication adherence. Since the TCC model requires less psychiatrist and psychologist time yet resulted in similar outcomes, it is a promising model to consider as shortages of psychiatrists and psychologists are severe.

In 2017, Medicare added billing codes to cover the CoCM model and general behavioral health integration (BHI) to support various integration and staffing models. Many commercial health plans followed Medicare in covering the codes and associated integration services. Medi-Cal, California's Medicaid program, covers the services. However, uptake of the codes has been slow across all payers as primary care practices face capacity constraints and adoption costs.

With persistent workforce shortages in both primary care and behavioral health, more flexible models of behavioral health integration are being tested that rely more on virtual integration and teams and care managers that can be supervised by offsite professionals. Outcomes for these models are more mixed and harder to evaluate. Researchers supported by PCORI developed an instrument, the Practice Integration Profile (PIP), designed to measure the degree or level of integration within a primary care clinic. The PIP instrument can be used in studies of behavioral health integration models.

Disclaimer

The statements and views expressed in this report are solely the responsibility of the authors and CHCC and do not necessarily represent the views of the Patient-Centered Outcomes Research, Institute (PCORI), its Board of Governors or Methodology Committee.