Embedding Integrated Behavioral Health Care into a Multi-Disciplinary Practice Environment

Case Study

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July 20, 2015

This case study manuscript is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.


**Introduction**

Responsibility for providing mental or behavioral health care has increasingly fallen to primary care providers (PCPs). With over 50% of visits to a primary care physician related to psychosocial issues, primary care physicians have struggled to find adequate time in their schedules to see the increasing volume. Physicians have also struggled to find available mental and behavioral health resources within their communities.

Researchers supported by NIMH have found that mental illness begins very early in life. Half of all lifetime cases begin by age fourteen and three-quarters have begun by age twenty-four. Thus, mental disorders are a chronic disease of the young. Unfortunately, evidence also shows that the mental health system fails to reach a significant number of people with mental illness, and those it does reach often drop out or get insufficient, uncoordinated care.¹

A hospital with a Pediatric and Obstetrics & Gynecology department, also felt the effects of managing mental and behavioral health needs for their patients. As the need for behavioral health services increased, these practices struggled to find the necessary resources within their own health system and community. Many patients, with limited resources themselves, found themselves relying solely on their primary care physician for these services. Primary care physicians are generally not trained to manage complex behavioral health disorders and, therefore, rely on the experts in the field. With the decreasing number of behavioral health specialists available to support the increasing demand for services, physicians are forced to consider creative approaches that will help their patients.

To assist PCPs in screening for, diagnosing, monitoring, and managing patients and families with behavioral health disorders, there are an increasing number of organizations that provide some level of support with the behavioral health integration model for practices in their health system.
**Alternative Decisions Considered**

One option considered was to continue assisting patients with their behavioral health needs. This option assumes physicians would continue to make referrals to local mental or behavioral health organizations when appropriate (traditional model). The advantages to this option are that patients remain with the practice and are “comfortable”. The practice can also maintain positive relationships with partnering mental or behavioral health specialists in the community.

The traditional model encourages primary care physicians to enhance their knowledge and skills related to common behavioral health problems and would continue to allow the behavioral health specialist to make the determination for the most appropriate services for the patient.

The disadvantages to this option are that primary care physicians would continue to manage their patient’s mental or behavioral health care. Taking primary responsibility for managing this care can be fragmented and not individually rewarding for the primary care physician. There are few behavioral health resources available in the community, leaving patients without care or sitting on waiting lists until an appointment becomes available. This option would also increase the likelihood of missed appointments with the behavioral health specialist if provided in a setting outside the primary or specialty care practice. This model does not allow for a real partnership with a behavioral health specialist and is less team-oriented. Additionally, referring patients to an outside behavioral health specialist provides no assurance that health information between the behavioral health specialist and the primary care physician is shared.

Another option considered was to hire a behavioral health specialist to be co-located within the building. Having this specialist on site would enhance access to care and increase the primary care physicians ability to contact the specialist, including using a warm hand-off from provider to provider approach whenever possible. This option would also increase patient and family
satisfaction as patients may feel less stigmatized coming to their primary care physician’s building for their behavioral health needs.

The disadvantages to this option are that access to care is diminished when not measured appropriately and does not respond to the high missed appointment rates for behavioral health specialists. Additionally, this model is less team-oriented and also does not allow for a real partnership with a behavioral health specialist. There is also no assurance of sharing information between the behavioral health specialist and the primary care physician.

Another consideration was to develop a behavioral health integration model using the structure outlined by a partnering mental / behavioral health organization. The advantages to this model are that it can be easily integrated into everyday primary or specialty care visits by offering a team-based approach. Because the behavioral health specialist is embedded into the primary or specialty care practice, there are several advantages that support the primary and specialty care physicians and the practice.

These advantages include:

- Integrates everyday primary or specialty care practice by offering a team-based approach
- There is a higher likelihood of kept appointments
- Reduces the burden on primary and specialty care physicians
- Increased physician and staff satisfaction
- Improved communication among care teams
- Enhances care teams existing expertise
- Allows opportunity to focus on patient outcomes
The advantages of this option for patients and families are the promotion of adherence with treatment by reinforcing ongoing contact. Additional benefits include improved patient/family satisfaction and lower costs. Studies have shown that integrated behavioral health systems do not increase mental or behavioral health expenditures. They may, in fact, not only lower inpatient and overall healthcare expenditures but also improve productivity at work and school.

Additionally, promoting the team based approach between the primary and specialty care physician and the behavioral health specialist helps the patient recognize that there is trust among the team caring for them. Patients may also feel less stigmatized seeing their behavioral health provider in their primary care practice.

The disadvantages to developing a behavioral health integration model are the up-front and long-term overhead and billing costs. Operational costs will need to be built into the practices’ financial goals. Additionally, the operational management of all aspects of the behavioral health specialist falls to the practice.

**Chosen Solution**

In April 2007, leaders of a pediatric practice attended a Mental / Behavioral Health Integration Conference coordinated by a larger organization within their health care system.

The conference was attended by primary and specialty care physicians as well as mental and behavioral health providers. Practices, who had been piloting the integrated model presented their stories and provided many scenarios of successful integration. Once the practices’ team, which included the medical director, practice manager and care coordinator, returned from the conference, a decision was made to present the behavioral health integrated model to the larger practice group for buy-in.
An implementation team was established that included the practices’ physicians, practice manager, care coordinator, a Licensed Clinical Social Worker and a Licensed Clinical Professional Counselor (LCPC). The foundation for an integrated model was considered and an outline of the model was provided to the rest of the practice. With the increasing demands for behavioral health services within the practices’ patient panel, and the few available resources in which to refer, the practice collectively decided to move forward with the integrated model.

The behavioral health specialist would be employed by the larger organization within the health care system, with direct supervision provided by them. The specialist would also have access to the larger organization’s psychiatric physician and physician’s assistant. All other operational items including scheduling, billing, documenting, etc. would be managed by the practice. The specialist would offer individual/family counseling services to patients (and their families) on site. Patients referred would be seen for brief solution focused therapy to assess and determine long term needs for the patient that would ultimately allow them to be successful. The model encourages the behavioral health specialist and the primary care physician to work together to make decisions about whether the patient will be referred to case management or additional behavioral health services within the larger mental / behavioral health organization. The brief focused therapy model should last no more than 60 – 90 days and a long-term plan should be in place for the patient by that time. Once this integrated model proved successful in the pediatric setting, the model would then be introduced to the Obstetrics & Gynecology group located in the same building.

Implementation

Beginning in April 2008, the practices’ leadership team, with support and guidance from a large mental / behavioral health center within the practices’ health care system, met to discuss the development of this model. The teams met monthly for several months to create a model that
would meet the operational and financial needs of both parties. The practices’ implementation team partnered with the larger mental / behavioral health organization to hire a Licensed Clinical Professional Counselor (LCPC) who was experienced in the integrated model. The practices’ care coordinator was partnered with the LCPC in an effort to manage appropriate referrals and timely scheduling of patients. The practice provided an exam room to the LCPC to allow for ease of provider to provider warm hand-offs. Brief solution focused therapy allowed the practice to maintain continuous referral patterns to the LCPC. Once a thorough assessment was provided a determination would then be made, along with the patient’s primary or specialty care physician, as to whether the patient requires long term support in order to be successful.

A workflow for completing prior-authorizations was constructed and managed by administrative staff. The leadership team worked with the ambulatory electronic health record analysts to create the ability for the LCPC to have full access to the electronic health record. The team also created a mechanism for allowing the LCPC to mark all mental and behavioral health related documentation as “sensitive”, in order to meet all confidentiality regulations.

The partnering mental / behavioral health organization facilitated an informational meeting with the practice that focused on the team approach to this integrated model, including how best to refer to the LCPC. The LCPC’s attendance at morning huddles with each care team was worked into each provider schedule and considered vital in order to determine potential warm hand-offs throughout the day. Providers from both teams agreed to maintain confidentiality and work collaboratively to manage and meet the needs of their patients. A referral workflow was created from the start of the referral to the scanning of the completed document from the LCPC.
Outcomes

Referrals to the Licensed Clinical Professional Counselor took several months to ramp up. Once the program was fully in place the following year, there was notable improvement in referral patterns and volume. By year two of the program the LCPC exceeded budgeted volume and revenue expenses. The brief focused therapy model appeared to be working well and met the demand for access for new referrals. Additionally, this new relationship allowed the physicians and the LCPC timely access to the behavioral health organization’s Child Psychiatry Access Project (CPAP), designed to offer a rapid response for requests for psychiatric consultation services. This program was specifically designed to support pediatricians and behavioral health providers working in a pediatric practice.

In 2014 the integration model was rolled out to the Obstetrics & Gynecology practice in the same building as the pediatric practice. The same model was followed though the concept was relatively new for this group. The ramp up period took longer than expected so a more standardized approach to referrals was implemented. Obstetric patients with an increased Edinburgh score (tool used to screen for post-partum depression) and teenage moms would automatically be referred to the LCPC. Additionally, the LCPC was located in an area that was not in close proximity to each physician in this group, therefore referral volume did not initially meet expectations. The group was creative and invited the LCPC to their weekly high-risk obstetrical meetings and also requested the LCPC be present at their morning huddles. The need for case management by the LCPC in this practice proved to be the most beneficial for their patients.

Overall provider satisfaction with the integrated behavioral health model was favorable. Providers were asked to rate the quality of the services the behavioral health clinician provides. 87.2% gave a rating of “very good” or “excellent”. When asked whether the behavioral health
clinician met the provider’s needs, 67.5% gave a rating of “almost all of needs have been met” or “all of my needs have been met”. When asked how satisfied providers were with having behavioral health services integrated into their practice, 97.1% gave a rating of “somewhat satisfied” or “very satisfied”.

![Graph showing the quality of services provided by behavioral health clinicians. The graph indicates that 52.9% rated the services as excellent, 34.3% as very good, 11.6% as good, 1.2% as fair, and 0% as poor.]
Lessons Learned

Consider potential challenges with warm hand-offs such as where the behavioral health specialist is located and the comfort level for physicians to interrupt a therapy session. The behavioral health specialist should be located in close proximity to all referring providers. The warm hand-off process should include an introduction from the primary or specialty care physician to the behavioral health specialist so the patient feels comfortable with the referral and also understands that the two teams are working collaboratively to meet the patient’s needs.

Consider measuring the potential demand for unmet services, prior to go-live. Use a method as simple as a check on a white board for every potential referral a provider sees in a day; and measure this for a few weeks.

Construct creative ways of informal communication between the behavioral health specialist and the referring provider, regarding shared patients on a routine basis. Some physicians prefer to communicate only through the electronic health record; some prefer a formal meeting each day, while others will check in with the specialist only in passing. There is no hard and fast rule about check-ins; only that communication occurs regularly.

Monitor access to the behavioral health specialist’s schedule closely. An integrated behavioral health model breaks down if access to an available appointment moves beyond 2 to 3 weeks.

When considering the credentials of the behavioral health specialist, also consider potential billing challenges with an LCPC (Licensed Clinical Professional Counselor) or an LCSW (Licensed Clinical Social Worker). Payor coverage varies depending on the level of the provider’s credentials and the services they can provide.
**Recommendations**

Consider inviting a practice that has piloted the model to some of the implementation team meetings so they can share their successes and challenges. When recruiting a behavioral health specialist, be sure the provider is flexible and potentially interested in additional hours in case the demand for appointments increases. Manage the operations of the specialist’s schedule as you would for any other provider by managing missed appointments closely and developing a process for follow-up to missed appointments.

All operational goals should be embedded into the practice and should also apply to the specialist, including:

- a. Cycle times
- b. Access and demand reporting
- c. Front end cycle (demographics, reminders, follow-up)
- d. Billing and collections

Finally take time to find the right behavioral health specialist that is the right fit for your practice and is committed to the integrated model.
ENDNOTES