2 Best practices

Evidence-based approaches to integrate behavioral and physical health

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Overview

> **“The addition of integrated behavioral health care [into primary care], when evidence-based and appropriately configured, can improve health and decrease the total cost of care.”**
>
> —Kathol et al.[1]

How well organizations manage patients’ behavioral health may well influence their success under value-based care, as patients with poorly managed mental health conditions often have high costs for both their physical and behavioral health care.[2]

As organizations pursue value-based contracts, many are integrating care for mental and physical health.[2] This approach may be relevant for any organization taking on two-sided risk and full responsibility for the care and health care costs of a population, such as accountable care organizations (ACOs).[2] Groups like the American College of Physicians and the American Psychiatric Association support such integration efforts.[3,4]

Yet integration can be challenging. Inefficient processes, inadequate data systems, and staff focused on traditional patient care approaches are all barriers to change.[5]

As more organizations move toward integration, several strategies have demonstrated positive results. This booklet provides a brief overview of four best practices for integrating behavioral and physical care that organizations might consider.

They include:

1. **Use standardized screeners**
2. **Implement key elements of care coordination**
3. **Utilize data analytics**
4. **Engage and support patients**

Models

> **The high prevalence of mental health conditions…that occurs with high medical need argues for integrated care models.**
>
> —Johnson et al.[6]

29%

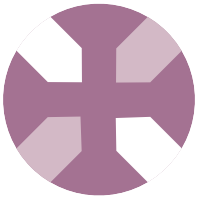
More than half of adults in the general population have a medical condition, and 29% of them have a comorbid mental disorder.[7] Often, these patients are seen in primary care settings.[1] Several models aim to make it easier for such patients to access mental health care.

Patient-centered medical homes (PCMH)

can support the integration of mental and physical health by using care coordinators to create an integrated, holistic care plan for patients while helping them identify and overcome barriers to improved health. Medical homes also use data from electronic health records (EHRs), claims, and patient registries to target patients with complex medical and behavioral health needs.[1]

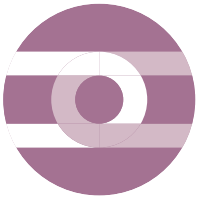
Behavioral health homes

support the integration of mental and physical health for poor and underserved populations in community mental health centers.[8] They improve access to medical and preventive care by integrating primary care services in mental health settings.[3] Behavioral health homes have been shown to improve the quality of care for patients with serious mental illnesses and cardiovascular risk factors.[8]



Collaborative care models

improve patient access to psychiatric care through close collaboration between a case manager and a consulting psychiatrist. They use a collaborative team, care coordination, and information technology. These models, which are recommended by the American Psychiatric Association, can increase the share of patients with bipolar disorder who receive appropriate medication as well as laboratory monitoring.[3,9]



The link to providing value-based care in ACOs

As they adopt new payment models, ACOs may benefit from approaches used in integrated care models. An integrated approach could lead to more efficient delivery of behavioral health care to patients with comorbid conditions while improving their physical health.[2]

Best practices

1 Use standardized screeners

Mental illness is often untreated or misdiagnosed.[10–12] Patients with bipolar disorder, for example, may not receive an accurate diagnosis for more than a decade.[11] Such patients have a heightened risk of comorbidities and suicide while the organization may incur higher costs.[11,13]

Detecting mood disorders

Screening is an effective strategy to identify adults with depressive symptoms and help guide clinical decision-making.[14,15] Effective screening in the primary care setting can help clinicians better coordinate a patient's mental and physical care and may lead to earlier connection to a mental health professional.[14]

A standardized tool such as the **Patient Health Questionnaire (PHQ-9)** is often used to screen patients for depressive symptoms in primary care settings. The PHQ-9 is a multipurpose instrument used for screening, measuring, and monitoring the severity of depression.[16]

Uncovering bipolar disorder

The depressive symptoms of major depressive disorder and bipolar depression are the same.[17] Because patients with bipolar disorder often present with depressive symptoms and rarely volunteer information about mania, providers may consider asking patients with depressive symptoms about previous manic or hypomanic episodes.[18–20] The self-reported **Mood Disorder Questionnaire (MDQ)** or the clinician-administered **CIDI 3.0**[21] can improve the efficiency in detecting bipolar disorder.[18]

Assessing anxiety

Anxiety disorder may be routinely assessed alongside mood symptoms in patients with bipolar disorder.[22] The **General Anxiety Disorder 7 (GAD-7)** is a self-rated questionnaire used to screen for general anxiety disorder and assess symptom severity.[23]

$115

saved per patient over four years

Example: Intermountain Healthcare

The Utah-based health system had higher rates of screening for depressive symptoms after integrating mental health care at primary care practices.[24]

Other results:

- Fewer emergency department visits, hospital admissions, and primary care visits
- **$115 saved per patient** after four years

2 Implement key elements of care coordination

65%

less likely to be admitted

Care coordination can improve outcomes in patients with depressive symptoms in a variety of settings.[3] One study found that patients with behavioral and medical conditions enrolled in an integrated care coordination program for at least 6 months were 70 percent less likely to use the emergency department and about 65 percent less likely to be admitted to the hospital.[25]

Key components of care coordination include:

- **team-driven care**
- **clinical information technology**
- **focused outreach**

Team-driven care works well for managing comorbid conditions because it often leads to better patient-provider interactions, as well as a more proactive clinical team.[3]

Central to this approach is the idea that by drawing on the skills and expertise of different team members, patients are more likely to get the care they need.[26] In these approaches, case managers play a key role in engaging patients to understand their treatment preferences and assessing treatment adherence.[3]

Payers sometimes provide a centralized team of care coordinators to support care coordination. In this role, they assist with care transitions and provide case management services for complex patients.[27]

Clinical information technology is vital to optimize population health management. Many IT systems allow teams to track patients (eg, registries), identify the next steps in their care, and use decision-support tools at the point of care.[1,3]

Focused outreach by phone, text, or email reminding patients to schedule a visit with their care team can help address care gaps. Through outreach, organizations also can assist patients with underlying issues, such as unmet social needs, that make it difficult to adhere to care plans.[27]

Payers also may conduct outreach to link patients to primary care physicians participating in alternative payment models in their area.[27]

$3300

saved per patient over four years

Example: IMPACT model

In five states, a nurse-led **care management model** for older patients with depression and diabetes saved **$3300 per patient over four years**.[28,29]

Best practices (cont'd)

3 Utilize data analytics

> **"It is important in using analytic systems to identify potentially high-cost patients to determine the patients' specific needs and gaps in care. It is especially important to identify and address behavioral health problems, because a large portion of the patients at high risk for hospital admission have some sort of behavioral health issue."**
>
> —Bates et al.[30]

Analytics can help support the integration of mental and physical health by identifying patients at risk for a range of diseases.[14,31,32] This includes patients with bipolar disorder and diabetes or bipolar disease and other cardiometabolic complications.[20,33]

Making predictions actionable

Predictive models link data from multiple sources, such as clinical data from the EHR, claims data, and patient-reported data, to predict patients at risk.[14,30,34]

Your Sunovion field medical directors can provide resources to help you use your data to reveal insights that can support your integration efforts, such as:

- Do providers in your organization utilize national guidelines for screening patients with depressive symptoms?[15,20,35]
- Which high-risk patients are not adherent to their treatment plan?
- Are patients who are taking atypical antipsychotics receiving cardiometabolic monitoring as recommended?[20]
- Are bipolar disorder patients receiving antidepressant treatment as monotherapy against current evidence?[36,37]

To understand how your organization's management of patients with bipolar disorder compares with national benchmarks, your Sunovion account team and field medical directors can provide you with a simple-to-use tool to import pharmacy and medical claims data and generate demographic information, treatment patterns, and resource utilization by patients with schizophrenia and/or bipolar disorder in your population.

$25,000

saved annually per super-utilizer

Example: Denver Health

When the health system used analytics to identify "super-utilizers" with serious mental health diagnoses for inclusion in integrated models, **average annual per person spending dropped nearly $25,000**.[6]

4 Engage and support patients

> **Patient engagement is essential for delivering high-quality, person-centered care and is a critical component for successfully implementing APMs [alternative payment models].**
>
> —Health Care Payment Learning & Action Network[27]

In value-based care, payment may be contingent on providers engaging and managing high-risk patients.[27] Yet organizations often have difficulty engaging those with serious mental illnesses.[38] Although there is no one-size-fits-all approach, several strategies may help.[38]

Patient engagement is considered a cornerstone of high-quality health care.[39] When patients are not engaged, they may not realize the full benefits of their treatment, causing their symptoms to worsen. For some with serious mental illness, this may even lead to rehospitalization.[38] Self-care is also important, as these patients have higher risks for asthma, coronary heart disease, fatal stroke, diabetes, and other conditions.[33,40–43]

Health literacy

Nearly 90% of adults lack the health literacy skills needed to perform more complex literacy activities.[44] Providers may assume that all patients and caregivers may have difficulty understanding health information and can simplify communication to improve comprehension.[45]

Shared decision-making

Understanding patient values and preferences is important to engage patients and help them make decisions that align with their goals.[27] Patients who report higher levels of shared decision-making have greater self-efficacy and a more positive attitude toward medications.[38]

Motivational interviewing

Through the use of open-ended questions, such as "What are you afraid might happen as a result of your (specific condition)?," and by practicing reflective listening, providers may be able to identify problems that could interfere with self-management.[46]

Behavioral change strategies

Providers can assist patients in making changes in their behavior by encouraging patients to self-monitor the specific elements of the behavior they intend to change (e.g., minutes of exercise, number of cigarettes smoked) and setting SMART (Specific, Measurable, Attainable, Relevant, Timely) goals.[47]

$594

saved per intervention per patient over two years

Example: TEAMcare model

Fourteen clinics in Washington State helped patients with depression plus diabetes and/or coronary heart disease **solve problems and set goals** as part of their collaborative care approach. Over two years, mean total outpatient costs were **$594 lower per intervention per patient**.[48,49]

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