

An abstract, colorful background featuring a silhouette of a human head in profile, facing right. The interior of the head and the surrounding space are filled with vibrant, swirling patterns of various colors including red, orange, yellow, green, blue, and purple, creating a sense of depth and complexity.

Behavioral Health Integration

Treating the
whole person



Physical health and
mental health
live in the same body.
We have to stop treating
them as if they are
two separate things.

Behavioral Health Integration

Hospital and health system executives know the behavioral health statistics, which include mental illness and substance use disorders. They see the tragedies in their own emergency departments (EDs) and can trace their roots, in part, to the lack of effective, integrated care for these conditions. They understand how the dearth of coverage for and access to behavioral health services leads to poor health outcomes and higher health care costs.

The question for many, though, is: What can we do about it? As behavioral health research is transforming the diagnosis and treatment of these disorders, one answer is behavioral health integration. For hospitals and health systems, this means integrating behavioral health services into every aspect of patient care, as well as coordinating and connecting with community resources. It means treating



DATA



1 in 5

Number of U.S. adults suffering from any type of behavioral issues in 2017.

Source: National Institute of Mental Health

the whole patient. It also means creating a continuum of care that reflects integration at each point in a patient's journey to better health.

This Market Insights report from the AHA Center for Health Innovation offers options on how hospitals and health systems can improve the availability and coordination of behavioral health services in three areas of patient care.

On the ED/inpatient side, hospitals and health systems can:

- 1 | Make behavioral health assessments routine for all patients, either directly or through telemedicine services, and have a process in place for referral/treatment if needed.
- 2 | Use their electronic health record (EHR) systems to prompt clinicians to assess all patients for behavioral health issues and ensure that they are shared with and addressed by all providers.
- 3 | Open geriatric psychiatric (geropsych/complexity intervention) units that are equipped to treat elderly patients' chronic physical conditions in addition to their psychiatric needs, or med-psych units that specialize in treating patients with dual physical and behavioral health diagnoses.

On the outpatient side, hospitals and health systems can:

- 1 | Embed behavioral health clinicians in outpatient settings in a collaborative care model.
- 2 | Equip and educate affiliated primary care practices with evidence-based behavioral health screening and assessment tools to use during each patient care visit.
- 3 | Document behavioral health screening, diagnosis and treatment in EHRs to improve care coordination.

- 4 | Open behavioral health urgent care centers that are integrated into urgent care centers that treat physical illnesses and injuries.
- 5 | For people with serious mental illness and substance-use disorders, develop a behavioral health home option.

To help extend behavioral health access and care into the community, hospitals and health systems can:

- 1 | Collaborate with, joint venture with, or merge with a community mental health center, certified community behavioral health center, and/or a variety of other community-based providers and stakeholders.
- 2 | Partner with other providers and community services to invest in data integration and develop innovative service delivery models for patient-centered care.
- 3 | Make virtual behavioral health triage services available to community groups, their members and federally qualified health centers.

The net results of successfully integrating behavioral health services are better behavioral and physical health for patients and their communities and better fiscal health for all. ●

ABOUT THIS REPORT: The AHA Center for Health Innovation developed this Market Insights report for hospital and health system executives who are working to integrate behavioral health into all care settings and collaborate with their communities to improve health care delivery for better health outcomes. This report is based on information and insights from a number of sources, including interviews with hospital and health system leaders and other health care experts, surveys of hospitals, and health care reports and research articles. A complete list of sources and other resources appears on Page 15 of this report. The AHA Center for Health Innovation thanks everyone for their contributions to this report.



Creating One System of Care for Physical and Behavioral Health

DATA



57.4%

Percentage of U.S. adults with behavioral illness in 2017 who did not receive behavioral health services.

Source: National Institute of Mental Health

Patients' physical and behavioral health are inextricably entwined. Yet, historically, the health care system developed along two separate and distinct lines: one that treats physical illnesses and another that treats behavioral health disorders. Efforts to end stigma, breakthroughs in brain science research and parity for coverage are all part of the shift to remove the social and systemic barriers for those living with behavioral health disorders.

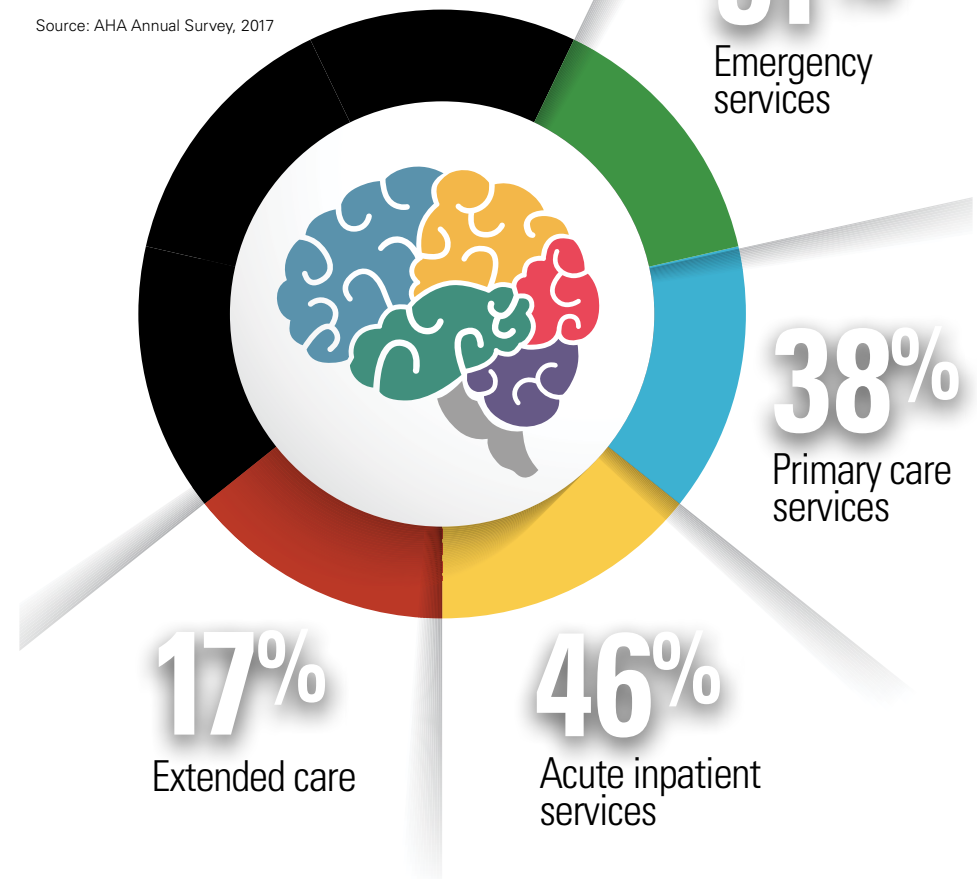
One patient. Two separate systems that attempt to collaborate with each other at best and that don't talk to each other at worst. The result is a fragmented approach to caring for the whole patient who has different but related medical issues.

Hospitals and health systems are working hard to change that: to create one system of care with multiple entry points for patients with multiple medical issues and to integrate behavioral health services into every patient's experience when and where patients need them to effectively treat the whole patient — both their physical and behavioral health care needs.

Before a hospital or health system integrates behavioral health services into its operations, it should know what integrated care means. Integrated care is the systematic coordination of physical and behavioral health care in acute care, primary care, emergency care, post-acute care, health homes and community-based services, when needed. Integrated care goes beyond collaboration or coordination between separate physical care and behavioral care providers. The aim of integrated care is one system of care for physical and behavioral health delivered by the care team with different clinical specialties along the entire care continuum.

Percentage of hospitals reporting routine integration of behavioral health services into the following areas. Integration ranges from co-located physical and behavioral providers, with some screening and treatment planning, to fully integrated care where behavioral and physical health providers function as a true team in a shared practice.

Source: AHA Annual Survey, 2017



Impact on Outcomes and Cost

Clinical integration leads to better outcomes and lower costs. Many communities mistake financial integration for clinical integration. Financial integration without clinical integration leads to reduced access, worse clinical outcomes, and generally greater overall total cost of care. Behavioral health carve-outs are also a challenge to integration. As health care is moving toward coordinated care, separation of funding places a significant burden on practices, patients and families as they try to work between two systems.

Behavioral health disorders have significant impact on individual and community health, utilization of services and costs. Costs are 75% higher for people diagnosed with both behavioral health and other common chronic conditions than for those without a co-occurring behavioral health diagnosis. In Medicaid, the cost of care is two to three times higher for beneficiaries with co-occurring behavioral health and chronic conditions. Patients with behavioral health disorders also have significantly greater spending for general medical conditions than patients

without a behavioral health disorder.

Also, people with behavioral health disorders are more likely to have other chronic medical conditions like asthma, diabetes, heart disease, high blood pressure and stroke. In addition, those with physical health conditions (e.g., asthma or diabetes) also report higher rates of substance-use disorders and “serious psychological distress.” As a result, those with behavioral health disorders — and co-occurring physical health conditions — are likely to use more services like hospital and ED care, which increase costs.

Increased access to behavioral health services is associated with improved health outcomes, patient satisfaction and quality as well as lower overall health costs. Research demonstrates that models that incorporate behavioral health into other medical settings are associated with positive impacts on behavioral and physical health outcomes as well as reductions in the use of acute services. To learn more about how increasing access to behavioral health services can improve outcomes and lower costs, download the [AHA report](#) “TrendWatch: Increasing Access to Behavioral Health Care.”

Integrating Behavioral Health into ED/Inpatient Care

In the Emergency Department

As hospitals and health systems well know, the rate of ED visits is on the rise. A 2018 study in JAMA Open Network found that nearly 30 percent of patients who visited a hospital ED had at least one behavioral health diagnosis. Also, the more severe the initial behavioral health diagnosis, the more frequently the same patient visited the ED the next year.

Consequently, integration of physical and behavioral health services in the ED can provide added value to the patients, providers and health care systems. That means making behavioral health clinicians available in the ED to assess, evaluate and initiate/refer to treatment patients regardless of the reason for which they came to the ED. Behavioral health clinicians can either personally assess and evaluate the patient, or consult with the ED physician who assessed the patient.

Telebehavioral Health and Digital Tools in the ED

Experts agree that, given the advancements in technology, every hospital and health system has expanded opportunities to provide access to behavioral health services in the ED. For example, in areas with shortages of behavioral health professionals, hospitals and health systems can

use telehealth to integrate behavioral health into their routine emergency care services.

Some hospitals and health systems are experimenting with behavioral health apps and kiosks in their EDs to assist patients and help doctors assess and evaluate patients’ behavioral health needs. After ED staff are able to rule out a life-threatening event, the patient answers survey questions that provide data to the practitioner using the self-help kiosk rather than waiting for a doctor to do the same thing. The kiosk sends the patient-reported information to the ED doctor, who can discuss it with the patient during the ED visit.

To learn more about the telehealth technologies and services available to hospitals and health systems, [download](#) “Telehealth: A Path to Virtual Integrated Care,” a recent Market Insights report from the AHA Center for Health Innovation. If your organization is starting a telebehavioral health program or strengthening an existing one, the AHA and the National Quality Forum have collaborated to produce “Redesigning Care: A How-to Guide for Hospitals and Health Systems Seeking to Implement, Strengthen and Sustain Telebehavioral Health,” a [playbook](#) which describes actionable strategies and interventions and links to a variety of other tools and resources.

2-3x

In Medicaid, the cost of care is two to three times higher for beneficiaries with co-occurring behavioral health and chronic conditions.



In Units and on Patient Floors

A patient admitted to the hospital for a physical illness or injury also should undergo a behavioral health assessment and evaluation as a routine part of his or her treatment plan. Similar to doing a history and physical, checking a patient's vital signs or dispensing

medications, a clinician can incorporate behavioral health questions, examinations, tests and treatments into the patient's inpatient care. At Cedars-Sinai Medical Center, Los Angeles, 95% of patients admitted to the hospital receive screening and evaluation for depression.

URBAN HOSPITAL CASE STUDY

Behavioral Health Assessment and Triage Center

TRUMAN MEDICAL CENTERS & OTHER AREA HOSPITALS | Kansas City, Mo.

A group of stakeholders in Kansas City — including representatives from law enforcement, hospitals, courts, city government, behavioral health clinics and homeless shelters — developed a unique solution to help those individuals with behavioral health disorders who don't require inpatient treatment but often end up in the ED or, worse, in jail. The group received funding from St. Louis-based Ascension, the city of Kansas City, area hospitals and the Missouri Department of Mental Health, and opened the Kansas City Assessment and Triage Center (KC-ATC) [program](#) in October 2016.

Individuals with mental health and substance use disorders — who don't meet inpatient criteria — are referred by approved EDs and Kansas City police officers to the KC-ATC, where they can be triaged and assessed. Individuals remain at the center voluntarily, and no walk-ins are allowed. The KC-ATC is staffed by a multidisciplinary team that includes registered nurses, caseworkers, mental health technicians, licensed social workers and advanced nurse practitioners who collaborate with a psychiatrist. Currently, 18 slots are available at the center — nine in the Sobering Unit for those currently under the influence of a substance and nine in the Stabilization Unit for those with a primary behavioral health issue.

"The KC-ATC has already had a significant impact for the citizens of Kansas City with acute mental health or substance abuse problems," says Kevin O'Rourke, M.D., director of clinical operations, emergency department, Truman Medical Centers. "It is an

important resource where local EDs can refer patients who do not need inpatient treatment, but need linkage to outpatient services. This helps increase area ED capacity and the ability to treat more patients, those who need inpatient behavioral health services and those who need other inpatient medical care, as well as improves the efficiency of ED operations." ●



DATA



\$1.7 billion

Annual compliance costs incurred by inpatient psychiatric facilities to meet three federal regulatory requirements affecting patient evaluations, safe care settings and emergency department screenings

Source: National Association of Behavioral Healthcare, 2019



LEARN MORE | Visit [AHA.org/center](https://www.aha.org/center)

PRO TIP

Use EHR system to prompt clinicians to assess and evaluate every patient for behavioral health issues and be capable of recording and sharing that information with all other providers along the patient's continuum of care.

Modules within EHR systems or handheld clinical decision-support tools can prompt clinicians to routinely collect that information and document the behavioral health services provided in patients' health records. Given the interconnection between physical and mental health, those initial assessments and evaluations often uncover a comorbid behavioral health disorder that can start being treated while the patient is in the hospital. This is especially important because depression among hospitalized patients is often unrecognized, undiagnosed and, therefore, untreated. Hospitalization represents an unrecognized opportunity to optimize both mental and physical health outcomes.

To treat such comorbid patients, some hospitals and health systems are opening geropsych units that specialize in caring for elderly patients with behavioral health issues that are exacerbating their physical health symptoms. Others are opening med-psych units for patients with acute dual complex physical and behavioral health diagnoses. Such units are staffed by multidisciplinary teams of caregivers that include behavioral health clinicians and specialists who develop and execute one comprehensive care plan that covers both a patient's mental/substance-use disorder and physical care needs.

Experts also recommend that behavioral health interventions start before surgery or treatment for physical care needs, not just after discharge. By treating the whole patient, they will be better prepared for surgery or treatment and for their recovery after leaving the hospital.

Hospitals and health systems that successfully integrate behavioral health services into their inpatient operations can enjoy a number of clinical, operational and financial benefits, including:

- Improved clinical outcomes.
- Fewer patients returning to the ED.
- Fewer inpatient readmissions.
- Improved ED patient throughput.
- Shorter lengths of stay.
- Lower costs in general and under value-based reimbursement contracts. ●

CRITICAL ACCESS HOSPITAL CASE STUDY



Geriatric Acute Behavioral Health Program

COTTAGE HOSPITAL | New Woodsville, N.H.

Serving a large region of New Hampshire and Vermont, [Cottage Hospital](#) is a critical access hospital with 25 acute care beds. In October 2016, the 10-bed Ray of Hope Geriatric Behavioral Health unit opened at Cottage Hospital. Specifically designed for older patients with persistent or late-onset mental illnesses, the interdisciplinary team, comprising a psychiatrist, gerontologists, registered nurses, licensed practical nurses, licensed nursing assistants, social workers and recreational therapists, provides a holistic patient-centered approach that attends to the mental, physical and psychosocial aspects of the individual.

Patients come to Ray of Hope via Cottage Hospital's ED as well as other hospitals' EDs, long-term care facilities, primary care physician practices and other settings. "They often come to us because something has changed recently in their mood or behavior," says Chief Nursing Officer Holly McCormack. "People in this age group may be seeing a lot of changes in their lives, such as family members and friends passing away, or maybe they're moving into a new living situation. Often, they have comorbidities. Anxiety and depression come up a lot, along with suicidal ideation." Length of stay is usually between 15 and 20 days, as medication adjustments take time when patients are being treated for multiple conditions. Specialists in caring for older populations, Ray of Hope behavioral health program caregivers work with families to put plans in place that allow approximately 40 percent of the patients to be discharged back to their homes. ●



Integrating Behavioral Health into Outpatient Care

DATA



78%

Percentage of rural adults surveyed who would be comfortable speaking to their primary care doctor about behavioral health issues

Source: American Farm Bureau Federation, 2019

If patients with behavioral health issues reach the hospital ED or an inpatient unit, it often means that their issues weren't effectively managed in an outpatient or less restrictive setting of care.

For hospitals and health systems, integrating behavioral health services into the daily operations of their affiliated primary care practices is a must, according to experts. That means supporting the affiliated PCPs and pediatricians with evidence-based, standardized behavioral health screening and assessment tools to use with each patient visit. Doctors, nurses or other trained staff screen and assess patients during their initial conversation and exam similar to taking a blood pressure reading. It also means teaching PCPs how to effectively use those tools and educating them on what to do with the information from those screenings and assessments. In addition, hospitals and health systems need to establish a continuum of services to which patients can be referred.

From there, the clinician can treat the patient during their visit, refer the patient to a behavioral health specialist for further evaluation

and treatment, send the patient to the ED, admit the patient to his or her affiliated hospital if the patient needs emergency or immediate acute care services, or refer the patient to community-based services when available.

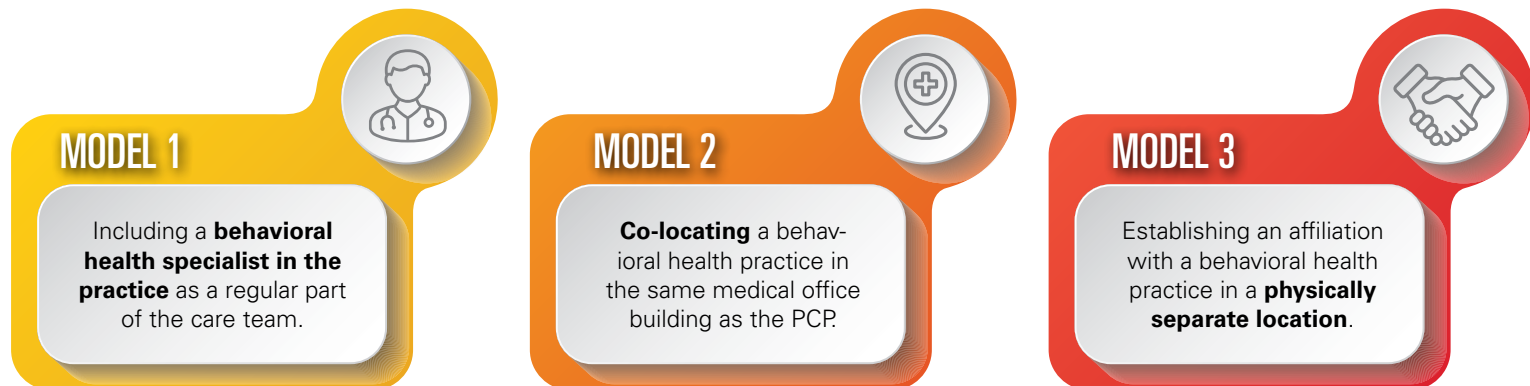
When behavioral health competencies aren't physically available on-site, PCPs, particularly those in geographic markets with few psychiatrists or other behavioral health specialists, may be able to access consultations via telehealth technologies. Remote specialists can consult virtually with them about a patient or connect with the patient virtually [see below for most common models].

Other hospitals and health systems are taking further steps by opening behavioral health urgent care centers. Some centers are stand-alone, while others are adjacent to or co-located with existing urgent care centers.

Whether PCPs with behavioral health specialists on staff, PCPs with telepsychiatry capabilities or behavioral health urgent care centers, the

Leading Outpatient Behavioral Health Integration Models

Some hospitals and health systems are developing formal behavioral health integration models for their PCPs. Below are three typical models from most integrated to least integrated.



clinical goal remains the same: Get patients the behavioral health and substance use disorder services they need before their conditions worsen.

Bi-directional integration: Behavioral health homes for people with serious mental illness

People with serious mental illness (SMI) — defined as a mental disorder resulting in serious functional impairment that substantially interferes with one or more major life activities, such as schizophrenia or bipolar disorders — are at high risk for multiple chronic disorders. For these patients, the integration model shifts. Instead of integrating behavioral health into primary care, primary care and specialty services are integrated into a behavioral health home model. Behavioral health homes are patient-centered medical homes designed for the specific needs of people with SMI.

Behavioral health home models can improve outcomes for people with SMI, as well as patient engagement in care. Research has shown that people living with SMI have a lifespan that is 14-32 years shorter than that of the general population. According to the National Institute of Mental Health, 85% of the premature deaths were due to largely preventable conditions such as high blood pressure, high cholesterol, diabetes and heart disease. One study reported that patients in behavioral health homes increased their use of outpatient physical health services by 36%. More importantly, utilization of the model is leading to fewer ED visits and fewer admissions, and helping people to live healthier lives. To address the physical health care needs of the underserved, at-risk group of people with SMI, providers have several options on how to structure the [behavioral health home](#), depending on the resources available.

- 1 | In-house model:** The health system supplies and owns the complete array of primary care and specialty [behavioral health services](#).
- 2 | Co-located partnership model.** The health system arranges for health care providers to supply primary care services on-site in behavioral health settings. This approach may be suitable for midsize organizations that have the infrastructure to develop partnerships but lack the resources and economies of scale to develop an in-house model.
- 3 | Facilitated referral model.** The health system conducts physical health screenings, links clients to primary care providers in the community and facilitates communication and coordination between the behavioral health provider and other health providers. This structure works for smaller providers and may also serve as a transitional model for those planning co-located partnership or in-house models in the future. ●

DATA



57%

Percentage of physicians and nurse practitioners surveyed between 2015 and 2018 who said that they didn't feel adequately prepared to screen patients for behavioral health disorders or substance use

Source: American Farm Bureau Federation

ACADEMIC MEDICAL CENTER CASE STUDY

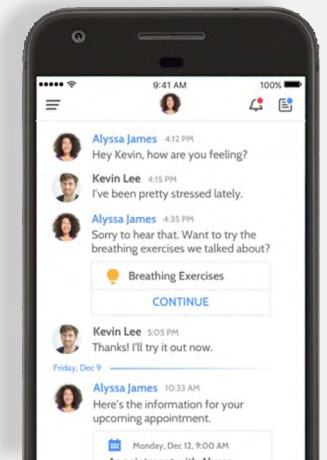
PCPs Leverage App for Behavioral Health

MONTEFIORE HEALTH SYSTEM | The Bronx, Westchester and Hudson Valley, N.Y.

In 2015, Montefiore Health System in New York City began implementing a [program](#) using the Collaborative Care Model (CoCM) to better serve its large population of low-income and minority patients with significant medical and behavioral health comorbidity and socio-economic challenges. A grant from the Centers for Medicare & Medicaid Services' Innovation Center helped Montefiore design, implement and sustain the CoCM to increase the availability and quality of behavioral services and test innovative reimbursement methods.

At the same time, Montefiore began looking for ways to leverage digital tools, developing a behavioral health registry in the EHR and piloting a smartphone application developed by Valera Health, to enhance care management capabilities and allow care managers to increase the number of patients with whom they interact. The program has helped the health system improve care for both pediatric and adult patients with behavioral health conditions, including depression, post-traumatic stress disorder, general anxiety disorder, panic disorder and alcohol use disorder.

Under Montefiore's CoCM clinical initiative, PCPs who treat patients with behavioral health are supported by a behavioral health care manager and psychiatric consultant. The behavioral health manager provides brief behavioral interventions, supports treatment initiatives delivered by the PCP and coordinates care with the PCP and psychiatric consultant using a shared registry to review and monitor the progress of patients. A licensed clinical social worker or psychologist is also part of the team and provides diagnostic confirmation and short-term psychotherapy when appropriate. Since adoption, the app has improved the effectiveness and efficiency of the CoCM by allowing behavioral health care managers to work with higher caseloads while maintaining key elements of the CoCM aimed at improving treatment outcomes. ●



Integrating Behavioral Health into Community Outreach

Hospitals' relationships with community-based organizations have made them central to addressing community-wide behavioral health care needs. Similar to the prevention and early detection of physical disorders, prevention and early detection of behavioral health disorders lead to better health outcomes for patients, better health for communities and lower overall health care costs.

It follows then, experts say, that hospitals and health systems that take a behavioral health integration approach to care delivery have seen improved outcomes and reduced costs, as evidenced by the continued success of [Montefiore's Pioneer ACO program](#).

One of the most effective ways for hospitals and health systems to determine the needs of their communities is to partner with community groups to conduct formal and regular behavioral health community needs assessments (see graphic below).

Based on the assessments, hospitals and health systems might partner with one or more groups to offer behavioral health educational programs

and conduct regular behavioral health screenings as part of existing community-based screening programs, such as those for cardiovascular disease or diabetes.

Hospitals and health systems also can make virtual behavioral health triage services available to community groups that, in turn, can make them accessible to their members who are more comfortable discussing their behavioral health concerns virtually than face-to-face with a clinician.

When the programs and screenings identify community members at risk for a behavioral health disorder, hospitals and health systems can connect those members with the appropriate level of behavioral health services in the continuum of care before those issues become acute.

Ideally, hospitals and health systems would be able to integrate their population health data-collection mechanisms with those used by community groups and unaffiliated providers to identify at-risk patients and target them for early and appropriate behavioral health interventions.

Community groups to partner with on behavioral health initiatives



DATA



2,538

Number of community mental health centers in operation across the country in 2017

Source: Substance Abuse and Mental Health Services Administration

PRO TIP

Partner with major employers in your community to launch an ongoing behavioral health stigma-reduction program for their employees

For behavioral health services in the community to be successful, executive leaders need to start by setting the tone within the health system. People with behavioral health conditions need just as much access to services as someone with cancer or heart disease. In nearly all cases, behavioral health services are break-even or are a service line that runs in the red. It's imperative to collaborate on behavioral health services with other hospitals in the same market to be able to identify service delivery gaps and then augment existing services. Working alone will not result in a better outcome and likely will drain substantial resources for other community needs. The most beneficial and cost-effective solution is to connect with these patients long before they end up in the ED or in crisis.

Partnerships with community mental health centers (CMHCs) are integral to providing behavioral health care services at the community level. Some hospitals and health systems own and operate their own CMHCs or enter into joint ventures, while others partner with freestanding centers. CMHCs are federally designated behavioral health treatment facilities that are certified to treat Medicare and Medicaid patients. There are more than 2,500 in operation around the country.

By taking an aggressive and proactive approach to behavioral health integration in their communities, hospitals and health systems can see more patients using their outpatient care services and fewer patients using their EDs for behavioral disorders. ●

HEALTH SYSTEM CASE STUDY



Substance Use Disorder and Community Collaborative Initiative

PRESBYTERIAN HEALTHCARE SERVICES | Albuquerque, N.M.

Presbyterian Healthcare Services (PHS) started a statewide [partnership](#) in 2017 called the Substance Use Disorder and Community Collaborative Initiative to deliver compassionate, high-quality, evidence-based care for patients with substance use disorder (SUD). Changing the culture of care to treating patients with SUD as any other chronic condition, devoid of judgment, is a key element of the approach.

An integrated, inpatient addictions medicine consult liaison team provides consultations for patients who are hospitalized for any reason. The team comprises a physician, nurse practitioner, physician assistant and a peer-support specialist who offer recovery support and work with patients to identify resources throughout the state. PHS universally screens patients for tobacco and alcohol use and soon will begin universal screening for problematic opioid use. Patients with SUD are often higher utilizers of medical care and may have comorbidities, such as cardiovascular disease, uncontrolled diabetes, depression or anxiety, so they require a holistic approach to their care.

PHS has built partnerships with faith-based organizations, churches and other SUD providers in New Mexico. For example, local pastors are trained to recognize signs of SUD and know where to refer parishioners for treatment.

From 2017 to 2018, prescriptions for buprenorphine, a medication to help people reduce or quit their use of opioids, increased by 50%. In addition, PHS providers decreased prescriptions for opioids by 16% while also dispensing more morphine-equivalent medications in a safer range. In 2018, PHS also tripled the amount of naloxone, an overdose reversal medication, prescribed as a universal precaution in the event of opioid overdoses.

This year, PHS is expanding SUD training beyond primary care and hospitalists to specialty care, including obstetrics and pediatrics. PHS is also customizing the training to meet the needs of communities around the state and offering it to other hospitals in New Mexico. ●



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Behavioral Health Integration Pathway

Behavioral health integration involves treating the whole person in order to improve health outcomes and patient experience without significantly increasing health care costs — as [AHA's 2019 Trend Watch](#) indicates, research has shown integration effectively implemented can reduce the total cost of care. Each organization can use the integration pathway below to evaluate their organization in light of their goals for a more holistic approach to care. Shifting focus to overall health and bringing together behavioral and physical health services into a fully integrated health care system requires cultural change, executive leadership and financial investments over a long period of time.

CAPABILITY	INTEGRATION LEVEL		
	COORDINATED CARE KEY ELEMENT: COMMUNICATION	COLLABORATION KEY ELEMENT: PHYSICAL or VIRTUAL PROXIMITY	INTEGRATED HEALTH CARE KEY ELEMENT: PRACTICE CHANGE
Care continuum and provider network management	<p>Network: Behavioral health and primary care providers maintain separate facilities and separate systems. Behavioral health is most often viewed as specialty care.</p> <p>Affiliation relationship: Limited criteria for affiliation.</p>	<p>Network: Behavioral health and primary care providers co-located in the same facility or behavioral health services are provided through teleconsultation. Providers may share some systems. Communicate regularly about shared patients.</p> <p>Affiliation relationship: Contracts require commitment to shared quality/utilization metrics.</p>	<p>Network: High levels of collaboration and integration between behavioral and primary/specialty care providers. Shared concept of team care and one integrated medical record.</p> <p>Affiliation relationship: Shared goals and accountability contingent on meeting quality and cost-management objectives.</p>
Case management	<p>Clinical protocols: Screening, assessment and evidence-based practices (EBPs) based on separate practice models. Referrals and shared protocols based on established relationships between physical and behavioral health providers.</p> <p>Care management: Providers view each other as resources and communicate periodically about shared patients.</p> <p>Population health-management tools: Use of disease registries and reporting. Some ability to track performance against quality/utilization benchmarks.</p> <p>Quality improvement: Quality improvement and disease-management programs exist, but are not coordinated across different parts of the health system.</p>	<p>Clinical protocols: Agree on specific screening, some EBPs and collaborative treatment for specific patients.</p> <p>Care management: Providers may feel as though they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.</p> <p>Population health-management tools: Population health-management system to identify high-risk patients. Complex patients with multiple health care issues drive the need for consultation.</p> <p>Quality improvement: Shared quality measures and a shared history of improved outcomes.</p>	<p>Clinical protocols: Population-based physical and behavioral health screening is standard practice. One treatment plan for all patients. EBPs team selected.</p> <p>Care management: Behavioral health working as part of primary care and specialties. Providers understand the different roles team members need to play and have changed their practice and structure of care to better achieve patient goals.</p> <p>Population health-management tools: High-risk, high-need complex patients are reliably identified and managed. Principle of treating the whole person is applied to all patients, not just targeted groups. Near real-time visibility into quality and cost performance.</p> <p>Quality improvement: Key performance indicators in an integrated care setting are population-based health status outcomes</p>

Adapted from: Heath, B. et al. "A Review and Proposed Standard Framework for Levels of Integrated Healthcare." Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions, March 2013.

(Continued on page 13)



Behavioral Health Integration Pathway (continued)

CAPABILITY	INTEGRATION LEVEL		
	COORDINATED CARE KEY ELEMENT: COMMUNICATION	COLLABORATION KEY ELEMENT: PHYSICAL or VIRTUAL PROXIMITY	INTEGRATED HEALTH CARE KEY ELEMENT: PRACTICE CHANGE
Patient Experience	Patient physical and behavioral health needs are treated separately with some warm handoffs. When patients are referred, barriers (e.g., stigma, scheduling) may prevent them from accessing care.	Patient health needs may be treated separately, but collaboration may include consistent warm handoffs with better follow-up, either in person or virtually.	All patient health needs are treated by a team that functions effectively together.
Data Exchange	Limited information sharing with other providers and existing community support services: Lack of standardization, data quality and patient identifiers in disparate systems.	Standardize communication with providers and community partners across continuum of care: Set protocols for expedited referrals, collaborate on treatment and discharge planning. Use of electronic health information exchange for coordinated information sharing among diverse providers and treatment settings.	Facilitated networks connect providers and community partners in a system of care: Use of role-based care management software providing care coordination, interoperability, analytics, outcomes and risk stratification. Addresses care transitions and long-term care needs. Highlights potential gaps in care, critical issues and social determinants of health (SDOH).
Community Partnerships	Identify and coordinate with existing community support services: Start a community cross-sector collaboration to address social SDOH.	Know and engage community partners across continuum of care: Address social needs in clinical encounter and select an SDOH strategy to improve health by balancing and integrating health care, public health and social services.	Community partners are part of the system of care: Leverage community partnerships to address SDOH and improve outcomes.
Operating and Funding Model	Operating units: Separate funding for primary care and behavioral health; may share resources for single projects. Financial model: Fee-for-service billing structures that stumble over same-day billing restrictions and rarely reimburse for consultations between providers.	Operating units: Separate or blended funding for primary care and behavioral health; may share expenses, staffing costs, or infrastructure. Financial model: Ability to negotiate and manage performance for contracts with downside risk; some risk mitigation in place.	Operating units: Resources shared and allocated across whole practice. Financial model: Global or blended funding structures support integrated health care; fiscally justified by improved patient outcomes that reduce overall health care cost.
Governance, Culture and Provider Engagement	Governance: Organization leaders regularly share information with each other and their teams. Culture: Some leadership in more systematic information sharing. Provider engagement: Ad hoc provider buy-in to collaborate and value placed on having needed information.	Governance: Organization leaders identify areas of opportunity for their teams to integrate care. Culture: Organization leaders supportive, but may view behavioral health as a project or program. Provider engagement: Provider buy-in to make referrals work and appreciation of on-site availability.	Governance: Key performance indicators for organization leaders are tied to population level metrics for both physical health and behavioral health outcomes. Culture: Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development. Provider engagement: Providers active in integration strategic planning.

Adapted from: Heath, B. et al. "A Review and Proposed Standard Framework for Levels of Integrated Healthcare." Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions, March 2013.



Scaling and Optimizing Integrated Care Models

The patient care benefits of integrating physical and behavioral health services suggest that such a strategy should be a clinical and organizational priority for any hospital or health system making the transition from fee-for-service to value-based care and population health management. Key to developing integrated care models is the tone set by executive leadership that incorporating behavioral health services into acute care, primary care, emergency care, post-acute care and community-based services is part of an organization's mission and values.

Key strategies outlined in this report are:

- Start somewhere; start small. Don't try to integrate behavioral health into the entire continuum of care all at once.
- Know and understand your population/community and their challenges and needs. Addressing the behavioral health problems will vary from community to community. It must start with a good community health needs assessment.

- Figure out what already exists in the community, where the gaps are. Decide how you can work collaboratively for a better outcome.
- Use evidence-based, standardized behavioral health screening tools in all settings and document in the EHR.
- Use technology to distribute your limited behavioral health resources more efficiently and equitably through telehealth and virtual consults.
- Use electronic health information exchange and care management software to improve collaboration, handoffs and transitions in care.
- Familiarize providers with the growing number of consumer-facing behavioral health applications that patients are using, and help patients use digital health tools, when appropriate, to manage their conditions.
- Measure the effects of behavioral health integration on key clinical, operational and financial performance indicators to show continuous improvement. Stress the goal of true transformation.

Hospitals and health systems that follow these strategies as well as other practices from peers on the leading edge of behavioral health integration can move the needle on caring for the whole patient — both mind and body. ●

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