Preparing Clinicians for the Future of Behavioral Healthcare

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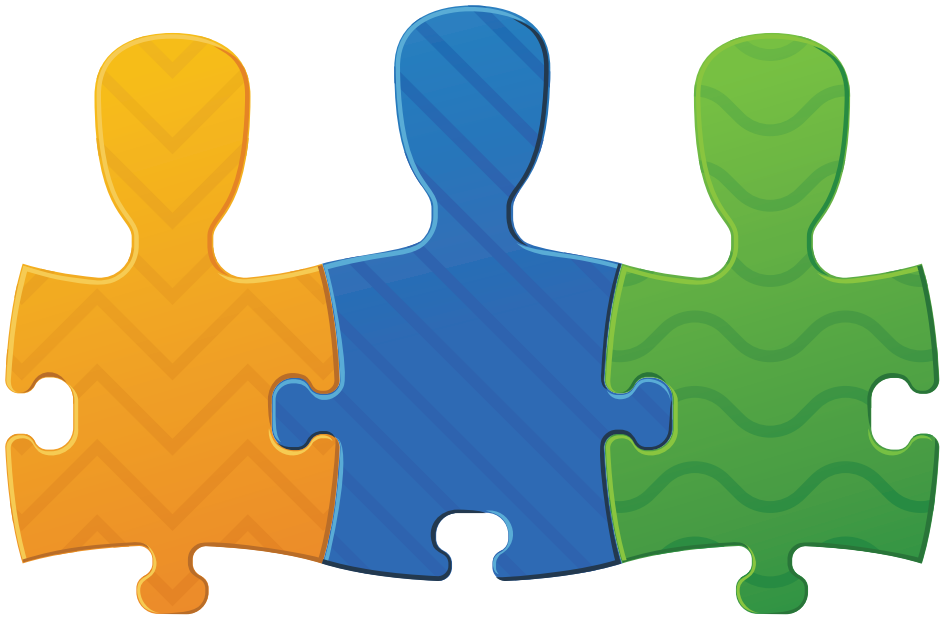
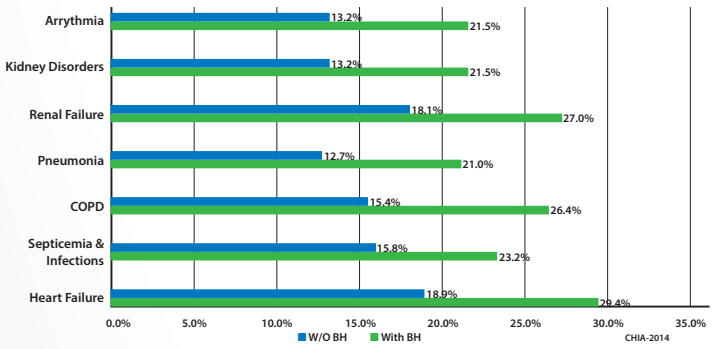


As we continue to move closer to the integration of behavioral health with general medical care, there is concern that Behavioral Health (BH) clinicians are ill prepared to work in a medical environment. Those who contend that "we've heard this before" should think twice before assuming that integration is just another "thing of the day." As data mining has become more sophisticated and as health systems dig deeper into the healthcare cost drivers, few can continue to ignore the cost disparities caused by behavioral health disorders. It is generally accepted that costs for patients with a medical condition who have a substance or mental health co-morbidity are 2½–3 times higher than for those without these disorders.[1] A 2014 analysis by the Massachusetts Center for Health Information and Analysis (CHIA) on hospital readmission rates revealed striking disparities in seven major medical conditions between patients with and without a BH co-morbidity.[2] (Figure 1)

READMISSION RATES & BH COMORBIDITY



In addition to these facts, it is reported that upwards of 70% of primary care visits are related to psychosocial issues but only 20–30% of these patients inform their Primary Care Physician (PCP) about their concerns.[3] Even when a PCP identifies an issue, it is well documented that few patients follow through and keep appointments with addiction or mental health professionals.[4] The evidence is clear and the opportunity to make a difference awaits.

Practice Methods in the Integrated Care Model

There are several variations on the models of integrated care as delineated by the Center for Integrated Solutions at the Substance Abuse and Mental Health Services Administration (SAMHSA) (Figure 2).

LEVELS OF "INTEGRATION"

- **LEVEL 1:** Minimal Collaboration – Separate Systems, little communication
- **LEVEL 2:** Distance Collaboration – Separate Systems, periodic communication
- **LEVEL 3:** Onsite Collaboration – Co-location, still separate; frequent communication
- **LEVEL 4:** Partial Integration – Same site, common scheduling/charting, but BH and medical still seen as separate entities
- **LEVEL 5:** Full Integration – Same site, same vision, same team, a full unified practice

These range from totally separate systems with a loosely defined referral arrangement to a fully integrated system where the BH clinician functions as a member of the medical team. The latter is the most effective and the one that requires a modification of traditional clinician skill set and practice methods. This skill set requires a new way of thinking about the clinician's role and purpose — more of a population health view than that of a specialty provider. The following table identifies these contrasting approaches.

Integrated Practice Model	Current Practice Model
15–20 minute visits	45–60 minute visits
No limit on # of patients per day	5–7 scheduled appointments
Open Access — Same Day Visits	Waiting Lists
Interruptible	Do Not Disturb
Instruct, Guide, Enhance	Diagnose and Treat
Minimal Stigma	Stigma Usually Very High
Patient "Ownership" is Shared	Clinician "Owns" the Patient
PCP Always Involved	PCP Rarely Involved
Interventions Support Medical Staff	BH Issues Addressed Independently
Documentation in a Unified Record	Documentation Stands Alone
Referrals from Medical Staff	Referrals from the Community
Clinician moves rapidly between patients	Clinician focused on 1:1 Interaction
No Cancellations	Frequent Cancellations or No Shows

These differences will require a considerable adjustment for clinicians who have spent years in specialty addiction or mental health clinics. Not everyone will be able to function in the fast-paced environment of a medical practice where visits are brief, solution oriented, and primarily supportive of a medical intervention. Are you willing to be a member of a team and do you have the political and personal skills to function in a busy medical practice? How comfortable are you moving between patients or being called into an exam room on a moment's notice to assist a medical provider? Can you adapt to a model that relies more on lifestyle modification guidance or instruction than on diagnosis and therapy? Does your skill set enable you to "share" the patient or are you more comfortable in an exclusive therapeutic relationship? These are just a few of the questions to consider.

The Advantages of Integrated Care

There are many rewarding aspects of doing clinical work in a medical setting and for those who take the time to enhance their skills, the task will be well worth it. Think of the opportunity this model presents — engaging with individuals before their condition becomes so acute that they have to go to a specialty behavioral health provider. Our current model sits back and waits for patients to get sick or desperate enough to finally pick up the phone and make that call. And then, when they finally do, often they are given an appointment several days or weeks out — enough time for them to decide they don't really need counseling. How much better is it for the patient to visit his/her PCP in a setting that has no stigma, in a waiting room with other patients none of whom know why the others are there? This is how care should be provided for most patients. And for those who may need something more than can be provided via a brief intervention in the PCP office, there is always the referral to specialty addiction or mental health care. It's not unlike what the physician might do when other health problems rise to the need for specialty care. If the EKG doesn't look right, your doctor may, at some point, determine that you need to see a cardiologist. It's the same with behavioral health — if the condition requires more intense intervention, the referral is made to specialty care. But, this time the collaborative relationship is established between the PCP and specialty BH care, with feedback loops on both ends. It starts to look more and more like a unified approach to healthcare, all to the patient's benefit.

Barriers and Challenges

It's one thing to advance a theoretical model and while there are many demonstrations of integrated care in the country, several challenges remain.

Significant Training Gaps

On both sides, the BH provider side and the primary care side, there is still insufficient understanding and appreciation for reciprocal value. Because this is a new approach, clinicians need in-depth understanding of what it means to work in a medical setting. And medical providers need to better understand that behavioral health issues are not always defined by the most extreme severity level.

Reimbursement and Regulatory Challenges

Because historically reimbursement for medical treatment and reimbursement for behavioral healthcare have been in two separate buckets based on separate systems of care, getting these services paid for remains a thorny issue. Sure, co-located BH provides can bill insurers but only as a mutually exclusive provider and that's not full integration.

Privacy and Confidentiality

Understanding the great concern with the privacy of sensitive behavioral health issues, I think this obstacle will ultimately be more perceived than real. The laws and regulations governing access to records of substance use disorder patients have been understandably restrictive. But, I believe that stigma can be greatly reduced through integration and, let's face it, treatment of the whole person in a unified system requires that there be information exchange.

The Dawning of a New Age

For some, the prospect of a new approach will be threatening. For others, it will be the opening of doors that have long been shut to behavioral health providers. I think about it this way. The number of diagnosable addiction cases in the USA is about 25 million; about 15% of those receive treatment, mostly from specialty addiction providers (detox, rehab, outpatient). That leaves about 21 million untreated. There's another cohort of about 60 million people identified as substance misusers. That's about 80 million people affected by alcohol or other drugs who don't get clinical attention. Where are they? Most of them go to their doctor for physicals or treatment for illnesses. This is where we need to be; this is where we can make a real difference; and this is where behavioral healthcare is going. It's time for clinicians to embrace the future.

(Notes)

[1]Melek, S., Norris, D., Paulus J., (2014), *The Economic Impact of Integrated Medical-Behavioral-Healthcare;* Page 4, Milliman American Psychiatric Association Report.

[2]Center for Health Information and Analysis, August 2016, *Behavioral Health and Readmissions in Massachusetts Hospitals.*

[3]Croze, C., (2015), *Healthcare Integration in the Era of the Affordable Care Act,* Prepared for the Association for Behavioral Health and Wellness.

[4]Slay, J.D., & McCleod, C. (1997) *Evolving an integration model: The Healthcare Partners experience. In N.A.* Cummings, J.L. Cummings, and J. Johnson (Eds.) Behavioral health in primary care: A guide for clinical integration (pp 121-144). New York: International Universities Press.

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