INTEGRATION

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FOREWORD

At Beacon Health Options (Beacon), we know that mental health matters. Mental health is what we do. In fact, it's all we think about. Many of our employees have lived experience themselves and/or in their families. We know firsthand that too often behavioral health care falls short. It can be hard to access and difficult to get clear answers about what to do and where to go for help. We believe that behavioral health deserves better.

Beacon's White Papers present our company's point of view on specific behavioral health matters. This White Paper is about integrated care because, in the wake of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, it's time to give behavioral health parity alongside the rest of health care. The concept of "integration" has emerged as a focal, all-purpose solution to remedy the known shortcomings. In this process, the integration narrative has sometimes espoused a view that specialty care management systems and integrated care models are diametrically opposed. We see it differently. We offer the following viewpoint.

Beacon's mission is to help people live their lives to their fullest potential. We simply cannot achieve this if medical and behavioral health systems remain in silos with behavioral health care shunted off to the side. In this paper, we present our vision for a transformative integration agenda to improve behavioral and medical outcomes for our members. Improved health is what we stand for, and we look forward to working with you to make this happen.

Timothy Murphy
Chief Executive Officer, Beacon

Executive Summary

INTRODUCTION

A multitude of definitions of “integration” exists in the scientific literature. This paper synthesizes the evidence base for the most effective models of behavioral health integration across a range of settings to improve health outcomes.

What is the problem we are trying to solve?
Mental illness and substance use disorders are common and have profound effects on physical as well as behavioral health and wellbeing. Although effective treatments exist for many behavioral health conditions, most people in the United States will not receive the care they need[1]. The health system is siloed with inadequate collaboration between primary and specialist care providers, including behavioral health. In specialty care settings, there is a need to better address the physical health needs of people with serious mental illness (SMI).

What do we mean by integration?
To integrate means to bring together diverse components, forming a stronger and more cohesive whole and working together. “Integrated care” does not mean simply colocating medical and behavioral health services or sharing a common electronic medical record. It cannot be effectively done by electronic communication and telephone interventions alone. Nor can it be achieved solely through educating primary care physicians or focusing only on screening without a comprehensive plan for treatments.

There are many models and examples of integrated care, but we looked to the weight of evidence to inform our point of view. Pioneered by the University of Washington, the best-in-class approach for integration is the “collaborative care model”.[2,3,4] This model, originally developed to support the delivery of behavioral health in primary care settings, has been expanded across different settings and for different population segments. While there may be variation among collaborative care models, all of them require organization around the following five distinct components that, when applied collectively, improve health outcomes:

1. Patient-centered team care
2. Population-based care
3. Measurement-based care
4. Evidence-based care
5. Accountable care

> “Successful integration calls for all practitioners, including behavioral health and primary care, **to cease working in isolation.**

For people with SMI, who are not optimally served by primary care, we advocate a model of Integrated Practice Units (IPUs) to complement the collaborative care model. This team-based model integrates primary care expertise into outpatient mental health clinics, where individuals with SMI have their principal connection to the health care system and receive regular care. Primary medical care may be provided through integration of a nurse practitioner and/or primary care physician into a specialist behavioral health care setting. In the context of Accountable Care Organizations (ACOs), this constitutes a specialist “SMI ACO”. For those people who are seriously mentally ill but not ill enough to require an IPU setting, the collaborative care model is able to tap into a highly responsive specialty system that provides wraparound services, including Intensive Outpatient Programs (IOP) and Assertive Community Treatment.

Conclusion

Successful integration calls for all practitioners, including behavioral health and primary care, to cease working in isolation. It demands shared accountability among all involved parties—payers, physical and mental health providers, and broader system stakeholders. This is not business as usual. None of that can be achieved without a system overhaul. Behavioral health—as a significant driver of total health care costs—cannot get lost in the mix. Therefore, consistent with the evidence base about what integration is and isn’t, we propose advancing a coordinated integration strategy in partnership with all industry stakeholders and the people we serve. The collaborative care model provides a launching pad for doing so.

Introduction

Integrating behavioral health services into medical settings is not new. Indeed, since its inception more than 80 years ago, "integration" has become a health care buzzword, but its precise meaning remains unclear. It is a term laden with biases, mostly influenced by where one sits in the system. At last count, more than 175 definitions of "integration" exist in the scientific literature, creating a "tower of Babel" effect that distracts from the core goal of driving improvement in health outcomes for the most vulnerable people.[5] To clarify our objective, this paper outlines the problem of care delivery fragmentation that we are trying to address and provides our proposed solution—to deliver better health via evidence-based best practice.

We know achieving integration is far more sophisticated than a reductionist agenda that is just about colocation or mental health screening. U.S. health care today is made up of multiple provider silos, not just between behavioral and physical health care, but across the entire sector. People with mental illness interact with a vast range of services, including the educational system, justice system, social service system and others.

However, most people in the United States and around the world with behavioral health problems go first to their primary care physician (PCP).[1] Studies have clearly established that PCPs are and have been "the hidden mental health network", of every country. That's why we outline in this paper, in a pragmatic and evidence-based manner, how behavioral health services can be effectively integrated into primary care settings—including for people with SMI. For those with SMI who do not optimally engage in primary care, we evaluate the evidence base for integrating primary care expertise into specialty mental health settings.

What is the problem we are trying to solve?

Mental health conditions—ranging from mild to serious—and substance use disorders are common, affecting greater than one in four of us at some point in our lives, but most people in the United States will not receive the care they need.[1] Inadequate collaboration among all health care providers is a pervasive problem, one that too frequently occurs between behavioral health and primary care providers. The various parts of the treatment system do not communicate with one another at a basic level. When asked why, providers report that they are not compensated to do so, and that as the volume of patients has gone up, the ability to provide any uncompensated coordination of care has become severely challenged.[6]

Wide geographical variation in models exists. However, 59 percent of PCPs report being unable to obtain outpatient mental health services for patients due to shortages and lengthy waitlists among local providers.[1] Even when referrals to specialists are made, individuals frequently don't show up. The stigma associated with seeing a behavioral health specialist is real. Beacon data reveal that the longer the referral takes, the less likely an individual is to attend his/her appointment. Even waiting a single day to be seen leads to a 25 percent no-show rate. In the meantime, such individuals have significantly higher rates of attending the emergency room (ER), and higher hospitalization and re-hospitalization rates.

Mental illness adversely affects physical health outcomes, leading to premature death, mainly due to cardiovascular disease and complications from diabetes. In 2012, additional health care costs resulting from people with behavioral comorbid conditions totaled approximately $293 billion for Medicare and Medicaid beneficiaries, as well as the commercially insured, according to a Milliman American Psychiatric Association Report.[7] However, those additional costs could be reduced from between 9 to 16 percent, for an estimated annual savings of $26 to $48 billion, through better integration of medical and behavioral health.

Complexity of mental health conditions thwarts integration

The needs of patients with mental health conditions are highly variable and complex. In fact, thinking about mental illness as any "one thing" is where we believe many efforts at integration get stuck.

Mental health conditions affect more than 1 in 4 people.

Take depression, for example. Depressive disorders now rank second in terms of overall global disability burden.[8] More than half of all adults with major depressive disorder are already managed in primary care settings, the *de facto* mental health providers both in the U.S. and abroad. Most antidepressant prescriptions today are written by PCPs. One of the starkest realities of all, however, is that approximately 45 percent of those who complete suicide have seen their PCP within the past month.[9]

Primary care is where the burden of illness is being seen, but despite their best efforts, PCPs sometimes have trouble providing the right care to meet their patients' needs. A recent study of 5,639 clinician-identified individuals with major depressive episode (MDE) revealed that only 38 percent of them actually met the *Diagnostic and Statistical Manual of Mental Disorders-IV* criteria for MDE.[10] Many of these individuals were prescribed unnecessary medications while those with MDE tended to be under-medicated.

However, integration efforts need to be broader than just addressing depression. Primary care also provides mental health care for those people with serious and persistent mental illness as well. Mental health prescription data reveal that PCPs generate a significant proportion of mood stabilizer and antipsychotic prescriptions for people with schizophrenia and bipolar affective disorders.[1] It is therefore inaccurate to say that people with SMI are not seen in primary care. Many individuals with SMI are already and increasingly will be—particularly in rural areas. To complicate the issue further, the social sequelae for this population are profound. Eighty to 90 percent of people with schizophrenia are unemployed; 20 percent are homeless; and 17 percent live in prison or jail.[11] To be successful, efforts at integration need to cater for this social complexity.

Serious mental illness has an extensive reach. For example, every year, approximately 100,000 U.S. adolescents and young adults experience first-episode psychosis, an experience that derails important developmental milestones at a critical life stage, such as completing school and entering the workforce.[11] Untreated psychosis increases a person's risk for suicide, involuntary emergency care, and poor clinical outcomes. A recent U.S. study of the duration of untreated psychosis reported a median rate of 74 weeks across 34 geographically diverse community mental health centers, more than six times the World Health Organization standard for effective early psychosis intervention.[11]

> “**Untreated psychosis increases a person's risk** for suicide, involuntary emergency care, and poor clinical outcomes.

Furthermore, substance use disorders are highly prevalent in the U.S. and, like mental health disorders, are predominantly seen in primary care. Opioid addiction is four times more likely in the primary care chronic population compared to individuals without chronic conditions. Despite the existence of evidence-based approaches, such as SBIRT (Screening, Brief Intervention, and Referral to Treatment), PCPs' training both for screening and treating substance use disorders often falls behind that for psychiatric disorders. Recognizing that substance use disorders present unique challenges related to integration, when referring to behavioral health integration throughout this paper, we include all mental illnesses and substance use disorders in this broader definition.

To conclude, the Affordable Care Act, Mental Health Parity and Addiction Equity Act and accompanying expansion of Medicaid, means that millions of previously uninsured people are entering the health care system. Many will already have worse overall health and more severe comorbid conditions, as they haven't had previous access to health care. For most, primary care will be their entry point. Primary care, the *de facto* mental health and substance use disorder provider, will be further overwhelmed.[1] Consequently, getting the integration of behavioral health care right matters now more than ever.

What "integration" is not

To avoid reinventing the wheel, below are some examples of great ideas that are frequently deployed but not proven to be effective as isolated interventions or strategies:

- Screening alone in primary care settings without adequate treatment or follow-up. We have 20 years of studies demonstrating screening alone doesn't work without a supportive follow-up structure.
- Provider education. Providers need systems and assistance to drive integration. While educational outreach visits have improved prescription practice, there is no evidence of actual improvement in clinical outcomes.[1]
- Simple colocation, without corresponding integration of care delivery protocols, is perhaps the most over-estimated approach to integration.
- Specialty referral as a route to specialists. Too often, people do not attend appointments.

- Tracking outcomes. While outcomes measurement can be helpful, an accompanying management plan is essential to change treatment if improvement is not occurring.
- Telephone-based disease management. Sixteen studies with circa 300,000 Medicare recipients show this approach doesn't work, primarily due to an inability to engage members most needing the intervention.[12]
- Integration is not achievable through payment reform alone.

What "integration" is: the collaborative care model

In our previous Beacon Health Options White Paper, "Confronting the Crisis of Opioid Addiction", (2015), we outlined and advocated for application of the Chronic Care Model for people with substance use disorders.[13] In this White Paper, "Integration," we advocate for an extension of Wagner's Chronic Care Model, the evidence-based practice of collaborative care.[14]

When we refer to "integration", we mean systematically applying the principles of the "collaborative care model".

While many models for integration exist, the collaborative care model has the strongest evidence base for integration. Pioneered by Dr. Unützer and colleagues at the AIMS Center, University of Washington, more than 80 randomized controlled trials have shown collaborative care to be more effective than usual care.[4] This finding has been further substantiated by several meta-analyses of the evidence, including a 2012 Cochrane Summary that reviewed 79 randomized controlled trials and 24,308 patients worldwide.[1] Although collaborative care is not new, this approach is not yet routinely adopted in all primary care settings as it is tantamount to a new way of practicing medicine. However, due to the evidence of its effectiveness—and improved patient and provider satisfaction—its adoption is increasing but needs to scale up further.

The collaborative care model's major contribution is in simplifying and operationalizing the model's critical elements for treating mental illness in primary care involving a greater role of nonmedical specialists. Studies have pointed to cost-savings as well, including both medical and behavioral health costs. One study, comparing financial outcomes of clinics practicing collaborative care versus those that don't, showed that while health care costs increased for all, the clinics practicing collaborative care experienced only 73 percent of the increase experienced by business-as-usual clinics, with a 54 percent decrease in ER utilization and a 49 percent decrease in inpatient psychiatric care.[7] In the geriatric population, return on investment of every dollar spent was $6.44. While substantial overall savings are experienced by the payer of health costs, expenses are incurred at the clinics where the model is implemented. This phenomenon necessitates an evolution of existing payment processes to compensate clinics for the additional quantity and value of care provided, which is further discussed in the Accountable Care section on page 25.

The largest trial for collaborative care to date is IMPACT (Improving Mood: Providing Access to Collaborative Treatment), a stepped care model for treating depression in primary care settings. This study showed, on average, that twice as many people significantly improved with collaborative care versus usual care—even though 70 percent of usual care patients were prescribed an antidepressant by their PCP.[2] Furthermore, these benefits persisted. In early 2014, a paper based on following IMPACT patients for eight years showed that patients with depression who received collaborative care were significantly less likely to experience a cardiovascular event than patients receiving traditional depression treatment.[15]

It is important to note that this model is increasingly being proven across a range of health care settings, from health maintenance organizations to OB/GYN clinics to community-based health centers and schools. The evidence is also rapidly expanding to include other common mental health problems, such as PTSD, as well as co-morbid medical conditions—heart disease, diabetes and cancer. Collaborative care has been proven to be effective for all ages as well.

As described by Unützer, the collaborative care model has five main principles for effective integrated health care.[1] While design flexibility is required for different environments, the evidence indicates that collaborative care requires all five of these components to produce the intended effect of better health outcomes:

1. Patient-centered team care/collaborative care
2. Population-based care
3. Measurement-based care
4. Evidence-based care
5. Accountable care

Below, we point to the evidence base that validates each of these principles. Applied collectively—and only collectively—these five principles set the stage for successful integration.

> “It is **no longer feasible** for any single clinician to retain all the relevant information and evidence for health care.

1. Patient-Centered Team Care

The literature of medicine currently contains about 24 million records and expands at a rate of 2,100 articles per day.[16] It is no longer feasible for any single clinician to retain all the relevant information and evidence for health care, which calls for the first basic tenet of integration: team-based care. Atul Gawande, MD, describes this reality as requiring a transition to the formation of “pit crews” in health care.[17] In primary care settings, the “pit crew” needs behavioral health player(s) to drive integrated care.

Typically in primary care, there are only two people involved: the PCP and the patient. The collaborative care model introduces two new team members: (a) care manager; and (b) consulting psychiatrist. Their respective roles are outlined in the following table: [4,12]

Primary Care Provider (PCP)	Care Manager	Consulting Psychiatrist
• Oversees all aspects of patients’ care • Diagnoses common mental disorders • Completes brief screens: (e.g., PHQ-9, GAD-7, PCL-C) • Starts and prescribes pharmacotherapy • Introduces collaborative care team and care manager • Collaborates with care manager and psychiatric consultant to make treatment adjustments as needed	• Provides patient education and self-management support • Closes follow-up to make sure people don’t ‘fall through the cracks’ • Supports PCP prescribing • Provides brief counseling, including behavioral activation, PST-PC, CBT and IPT • Facilitates any required treatment change and/or referral to mental health • Focuses on relapse prevention by creating a plan with the patient	• Provides caseload consultation for care manager and PCP (population-based) • Provides diagnostic consultation on difficult cases • Consults on patients not improving as expected • Provides recommendations for additional treatment or referral according to evidence-based guidelines

PHQ-9: Patient Health Questionnaire-9
GAD-7: Generalized Anxiety Disorder-7
PCL-C: Post-traumatic Stress Disorder Checklist-Civilian Version

PST-PC: Problem-solving Treatment
CBT: Cognitive Behavioral Therapy
IPT: Interpersonal Therapy

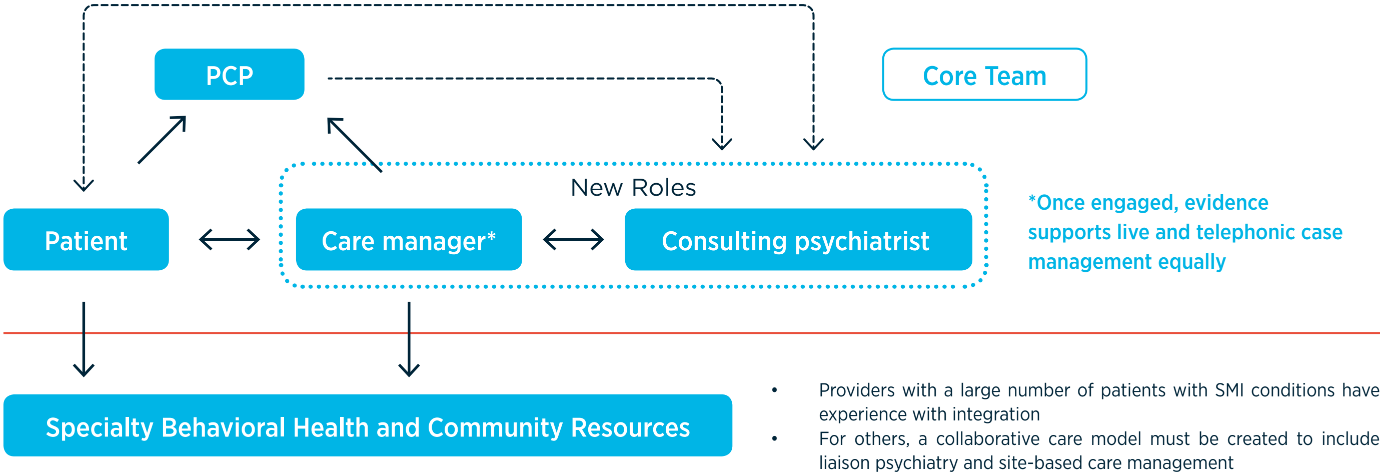
The social model of recovery

Consistent with a social model of recovery is the recognition that a medically led approach alone will not exclusively meet all of our patients' needs. Thus, the care manager role is pivotal in an integrated care team, connecting the dots between medical and behavioral health professionals. Care managers may come from a range of backgrounds, including social work, nursing, psychology or other types of mental health counseling. In addition to supporting and providing evidence-based assessments and treatments, care managers play a crucial role in close follow-up, supporting PCP-prescribed treatments, and providing patient education and self-management skills. They also participate in nonclinical components of care, such as managing transportation needs and identifying community supports. Of most added value is the ability of care managers to deliver evidence-based talking therapies.[4] Improving access to such therapies has the added advantage of avoiding more long-term medical problems resulting from prescribed medication side effects, which include the impact of weight gain on the cardiovascular system and associated risks of developing metabolic syndrome. (See Figure 1 for a graphic of how team-based care works in the collaborative care model.)

However, the social model of recovery does not stop with care managers. There is a growing body of evidence for peer-delivered services as well. Numerous randomized controlled trial studies now demonstrate that peer-provided services produce outcomes that are as good as, or better than, services from non-peers, particularly in employment, Assertive Community Treatment and Intensive Case Management.[18]

While colocation brings benefits, it is not essential or sufficient. Additional pressures relating to the current fiscal environment may make any additional onsite staff—professionals and peers—beyond the reach of many primary care practices. In this case, telemedicine-based collaborative care has been proven to be effective. Although telephonic disease management when delivered in isolation is ineffective as noted above, telephonic care management is effective as part of the collaborative care model because of its proactive member and provider outreach for the organization of person-centered care.

Figure 1:
Team-based care model



*Once engaged, evidence supports live and telephonic case management equally

- Providers with a large number of patients with SMI conditions have experience with integration
- For others, a collaborative care model must be created to include liaison psychiatry and site-based care management

New technologies can expand the reach of collaborative care, far beyond face-to-face encounters, making it more feasible for rural and small practices. Such technologies incorporate the online delivery of evidence-based interventions, including cognitive behavioral therapy (CBT). For many "digital natives", online approaches are preferable as they offer scheduling flexibility and immediacy, mitigating the need for travel. Such flexibility yields lower dropout rates and fewer missed appointments. For example, IESO is an online team of accredited clinicians who provide text-based CBT at scheduled times for those interested in electronic therapy. As there is a written record of all interactions, the oversight is more thorough than face-to-face interactions. IESO can also use the collated data for intense coaching purposes. This approach achieves a 48 percent recovery rate at 40 percent of the cost versus an average 44 percent recovery rate in the control group at four months.[20]

In summary, a team-based approach is critical in a primary care setting. This approach, combined with technology when applicable, drives person-centered, integrated care based on a social model of recovery.

The role of psychiatrists in a collaborative care model: treat the most mentally ill

Until the early 20th century, psychiatrists were known as "alienists".[21] Because they practiced in asylums isolated not only from the rest of health care but also from society, they earned the stereotype as being aloof and segregated. Yet, treatment by psychiatrists has been demonstrated in many research trials to positively contribute to better patient outcomes and improved health care resource utilization.

MCPAP

Massachusetts Child Psychiatry Access Project

A telephone-based approach to collaborative care is best exemplified by the Massachusetts Child Psychiatry Access Project (MCPAP), a statewide integrated care initiative.[19] MCPAP was designed to address the lack of access to child psychiatry, as documented in the Surgeon General's 2000 *Report of the Surgeon General's Conference on Children's Mental Health.* In the MCPAP model, six teams across Massachusetts offer the following services to enrolled pediatric primary care providers:

1. **Real-time telephone consultation with child psychiatrists, within a maximum of 30 minutes**
2. **Face-to-face appointments when indicated for acute psychopharmacology or diagnostic evaluation**
3. **Assistance with accessing community-based behavioral health services when needed**
4. **Educational resources**

In addition, MCPAP is training all enrolled practices to use the new S2BI (Screening to Brief Intervention) substance use screening tool for adolescents, designed specifically for pediatric primary care settings.

Since launching, MCPAP has served 45,523 unique patients, enrolled 447 practices with 2,998 providers. MCPAP has also provided 23,344 face-to-face psychiatric evaluations and 50,386 referrals for community-based services. With a recognized national shortage of child psychiatrists, more than 30 states have now developed child psychiatry consultation programs based on MCPAP. Furthermore, McLean Hospital in Massachusetts is piloting the extension of MCPAP's services to school nurses, demonstrating the broader potential for integration across sectors.

Moreover, the number of practicing psychiatrists in the United States is predicted to decrease over the next few decades, and 40 percent of psychiatrists do not take insurance.[22] Yet many health care professionals are not currently practicing at the "top of their license," meaning they are not performing the work that reflects the fullest extent of their training. Applying this reality to the collaborative care model means we can no longer rely on individual face-to-face appointments from our most highly specialized mental health workforce. The collaborative team approach addresses this shortfall by redefining access and leveraging psychiatrists' skills so that they treat only the most severely ill individuals who frequently have complex comorbidities. This approach relies on effective lines of communication and collaboration with PCPs and staff, which is at the heart of the collaborative care model, and by extension, integration.

Instead of offering outpatient appointments weeks in advance, the collaborative care approach limits the number of pre-booked appointments to facilitate access via same-day walk-in appointments. To that end, psychiatrists may offer shorter visits (15 to 30 minutes duration) with shorter follow-ups. More complex individuals will inevitably require longer time. "Warm handoffs" from PCP to psychiatrist occurring in both office-based and virtual settings replace written referrals. An in-person introduction also serves to increase patient engagement through reducing stigma and enhancing the continuity of care. For a seamless transition, the clinic's layout matters, including common workrooms for clinicians and support staff to encourage spontaneous interactions.[23] Colocation only enhances integration when it is accompanied by comprehensive integration of care delivery protocols.

Typically in a collaborative care setting, consulting psychiatrists will spend three hours per week for each care manager's primary care caseload (typically 50 to 100 patients).[12] They will use this time to systematically review all patients in a care manager's caseload for whom there are diagnostic or therapeutic questions and provide recommendations for further assessment and treatment. This set-up enables psychiatrists to serve a far larger population than in a traditional, office-based practice. However, it also has implications for reimbursement, as discussed in pillar 5, on Accountable Care.

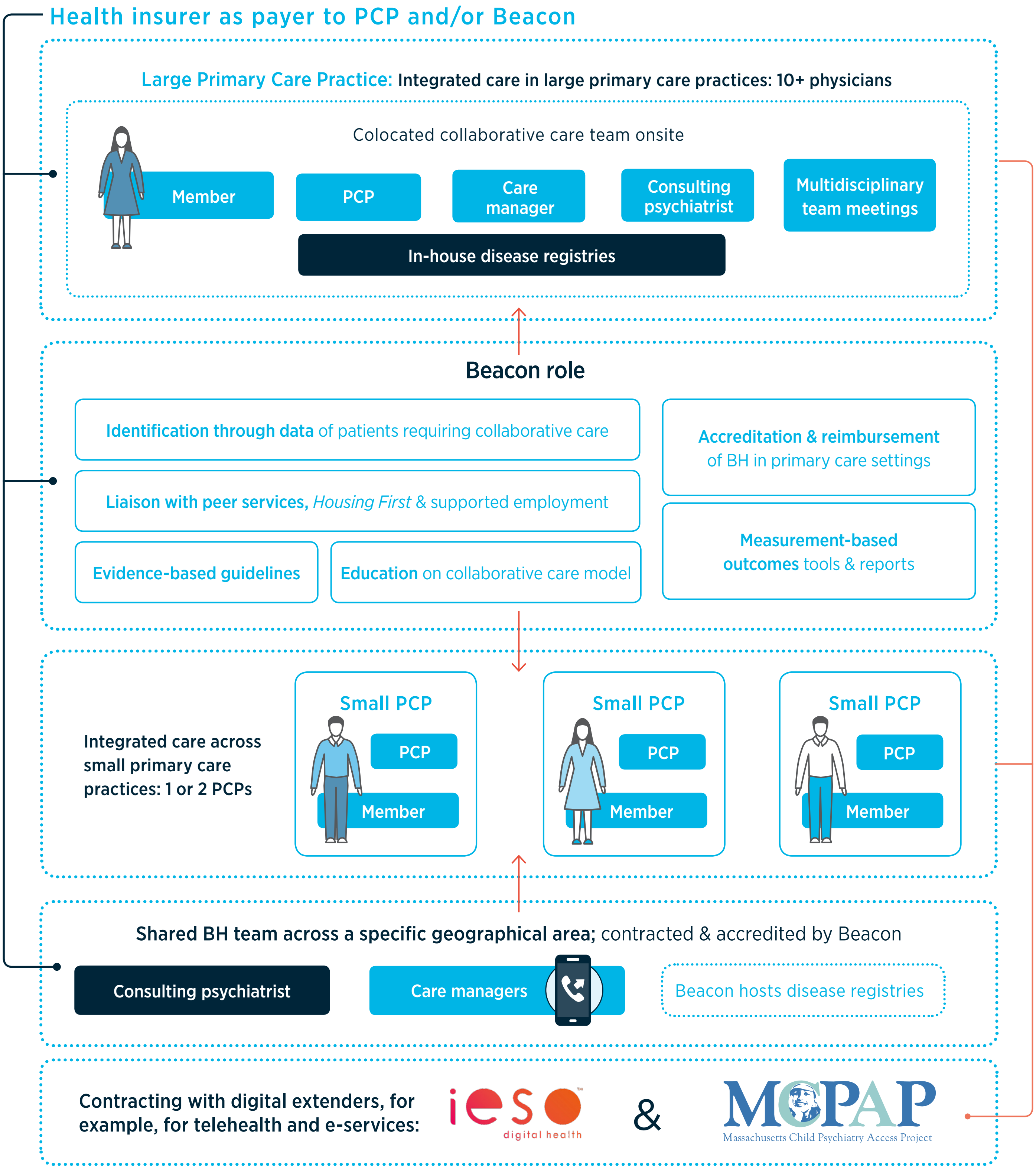
Overall, integration proffers a fundamental step-change in the role of psychiatrists that current professional training does not yet reflect. Psychiatrists will require training for their new collaborative primary-care based and virtual roles, to lead teams, and to track and monitor psychiatric and medical outcomes. However, only limited training in specific competencies for integrated care currently exists from professional bodies.

The role of primary care physicians

The PCP continues to be at the core of integrated teams, overseeing all aspects of a patient's care but now able to collaborate with a care manager and a psychiatric consultant to make informed adjustments to treatment, as needed. Primary care physicians are responsible for prescribing psychiatric medication, in close collaboration with psychiatrists who provide ongoing guidance to avoid under- and over-prescribing, as well as over-reliance on medication that may not be indicated. They must have the fiscal support to discuss and plan care for their patients with the other members of the collaborative care team. Therefore, PCPs will also need some retraining in how to operate in the new collaborative care model.

In this model, the number of PCP contacts remains roughly the same. People with mental illness are likely to have an additional 10 contacts with their care manager per year, and on average, two case consultations will take place annually between the psychiatrist and the care manager/PCP.[4] (See Figure 2 for a graphic of the collaborative care model in PCP settings.)

Figure 2:
The role of Beacon in supporting the collaborative care model in large and small primary care practices



PCP: Primary Care Provider • **BH:** Behavioral Health

● Services provided primarily by external vendors

In summary, simply colocating a care manager and a psychiatric consultant won't magically make a team. This model requires investment in team-building, establishing program goals and a shared vision. Primary care physicians, psychiatrists and behavioral health care specialists will need to be engaged and enthusiastically accept their roles in this new care model; they must be given the fiscal support for teamwork that is outside of direct patient visits but that has a huge impact on outcomes. It is not business as usual. Further, of paramount importance is the patient's motivation to participate, often referred to as "engagement". Historically, the health care industry has not paid sufficient attention to patient engagement. As we redefine psychiatric care in integrated care settings, there is a substantive opportunity to drive engagement in a way that will overcome the stigma typically associated with seeking behavioral health treatment.

2. Population-Based Care

An important goal of integrated care is to ensure that the people who need care the most don't get lost in the system. To that end, part of the ongoing assessment and clinical workflow of effective integrated care includes periodically reviewing outcome metrics at a population level. This review warrants the data collection capacity of registries, the cornerstone of driving improvement in all chronic conditions, both behavioral and physical. Registries help us identify and then deliver appropriate evidence-based behavioral health treatment at a population level, more so than electronic medical records alone, which store unstructured data about individual clinical activities only. Population-based care requires expertise to aggregate data from varying sources to complete the analysis for predictive modeling and care-gap identification. Such functionality is typically beyond the reach of any individual provider or practice. Touching multiple points across the system, managed behavioral health organizations—such as Beacon—are well positioned to support health data integration, ensuring the inclusion of behavioral health data alongside medical and pharmacy data.

Big data facilitates targeted interventions

"Predictive modeling" is a general term used to refer to the use of already acquired health data to identify members in a health system who are most likely to develop serious illness; experience a preventable decline in functioning due to an unmet care need; require significantly higher health care services than the average member; or generate higher health care costs. In theory, this kind of statistical approach enables us to stratify populations for targeting interventions. In practice, attempts at predictive modeling in health care have only been modestly successful. Kansagara, et al. reviewed 26 unique risk prediction models for hospital readmission and found that only 14 were potentially useful. A 2011 J*ournal of the American Medical Association* article evaluated the impact of a risk model for identifying patients with risk for readmission and noted the model "performed poorly".[24]

One of the major contributors to poor performance of predictive models is that mental illness and substance use disorders are frequently excluded. We know that behavioral health conditions generate an inordinate amount of health care costs, both by themselves and as comorbid conditions that worsen physical health outcomes and increase medical utilization. Furthermore, analysis of the top 5 percent of highest cost Medicaid beneficiaries invariably shows that those people in this cohort with mental illness or substance use disorder drive the top 50 percent of overall health care costs.[25]

The combined efforts of predictive analytics and tracking patients via a registry mean that no one “falls through the cracks”. Moreover, registries’ data-driven, population-based approach enables the collaborative care team to be more efficient by outreaching to individuals most in need who may not be improving, rather than being a reactive system providing ad-hoc advice to whomever walks through the door.

> “The combined efforts of predictive analytics and tracking patients via a registry mean that **no one “falls through the cracks”.**

There are many ways to host a registry. What matters most is having and maintaining one and ensuring that it is interoperable with electronic health records as a further guarantee that patients don’t slip through care gaps. Below are commonly tracked metrics that inform care approaches and subsequent staffing needs:[4]

Clinical Outcomes	Key Processes of Care
1. Number and proportion (%) of patients in treatment for at least 10 weeks with significant clinical improvement as measured by a validated rating scale (definition of “significant clinical improvement” varies based on the condition being measured and the measurement tool being used). Minimum goal should be 40% of patients demonstrating significant clinical improvement. 2. The net change effectiveness score in key health indicators, measuring the difference between: a. Proportion of patients (%) in active treatment who have a baseline measure of the clinical condition(s) being treated and the mean (average) of that score b. Proportion of patients (%) in active treatment who have a follow-up measure of the clinical condition(s) being treated and the mean (average) of that score	1. Total number of patients discharged (no longer active) 2. Total number of patients active 3. Proportion (%) of active patients receiving any kind of follow-up (in-person, group, phone) during past month 4. Mean (average) number of contacts since treatment started 5. Mean (average) length of time in treatment 6. Proportion (%) of patients in treatment who have been reviewed by a psychiatric consultant who has made recommendations to the primary care-based treating medical/behavioral health providers 7. Proportion (%) of patients in treatment for at least 10 weeks who are not improved and who have not been reviewed with the psychiatric specialist

Ensuring all members of the care team have access to a shared record—and disease registry—is vital in enabling whichever member of the collaborative care team sees the patient to log treatment response, any complications and to capture outcome measures.

Recognizing the real issues of protecting privacy and civil liberties, current legislation inadvertently acts as a barrier to sharing information regarding previous history with providers and with members’ support systems, such as family members or recovery coaches. Legislation also limits communication among providers. One example of how Beacon has overcome this fragmentation, in partnership with our New York clients, is through a universal data release form, shown in the Appendix. This form permits data release from a member perspective across multiple providers, making one of the most fundamental requirements of integration possible.

3. Measurement-Based Treatment to Target

There is no value in team-based, integrated care if there is no proof that it works. To that end, one of the major advantages of the collaborative care approach is systematic feedback on outcomes, which galvanizes team buy-in for the integration process. Indeed, we are moving to a world of: "If you don't measure it, it didn't happen". The era of measurement-based care (MBC) in behavioral health is upon us, which involves committed follow-up to ensure that no one falls through the cracks and that treatments are adjusted until patients reach substantial clinical improvement.

> "We are moving to a world of **'If you don't measure it, it didn't happen'.**

For behavioral health disorders, there are no validated laboratory tests or imaging studies that define severity of illness. Many of the risk factors inherent in behavioral health outcomes relate more to social and demographic variables. In the absence of any strategic framework for measuring the outcomes of mental health care, the health care system defaults to measuring the only thing that it can—spending on mental health services.[23] Further, "management" of mental health is misinterpreted as controlling that spending rather than increasing the value it might create.

'Treatment to target'
The concept of "treatment to target" means that if patients are *not* improving, as expected, the treatment needs to be changed until progress towards the clinical goals is made.[1] Measurement allows us to target where that treatment is—and is not—working along the continuum of care, whether it be social, behavioral or physical. While the concept of MBC in general isn't new, much like the other tenets of collaborative care, it is not yet standard clinical practice. Today, only 18 percent of psychiatrists and 11 percent of psychologists in the U.S. routinely administer symptom rating scales to patients to monitor improvement.[26]

In the absence of capturing progress, it is impossible to know what treatment(s) are effective versus not, at an individual and population level, making the measurement-based treatment to target approach imperative to all care plans. Such person-centered care plans are central to the success of integrated care as they not only organize the varying treatment modalities around individual patient needs, but also the corresponding health care professionals.

The “treatment to target” approach is sometimes called the stepped care model. It guards against the “clinical inertia” pervasive in our treatment approaches today. At least 50 to 70 percent of all people will require at least one change in treatment to improve. Each change in treatment moves an additional 20 percent of patients into response or remission.[4] Using standardized measures provides a common language to communicate progress among team members, which is critical to the success of integrated care. Patient self-report questionnaires such as the PHQ-9, shown in the Appendix, can be used as screening tools as well as to monitor progress. Although socioeconomic factors such as poverty, injustice and despair can also inadvertently lead to high scores, these types of metrics only ever form part of an overall holistic evaluation.

> “Only 18 percent of psychiatrists and 11 percent of psychologists in the U.S. **routinely administer symptom rating scales** to patients to monitor improvement.

The role of clinical assessment, therefore, is to distinguish depression from demoralization, a distinction that has been supported by decades of research. Collecting outcome measures doesn’t necessarily need to take up valuable clinician time. Many of these questionnaires can be completed by individuals themselves or with the assistance of family members. Another advantage to patients completing self-report questionnaires is that it enhances patient engagement, which in turn, results in improved patient experience and improved outcomes. In Florida, Beacon is currently using iPad surveys in community health centers to capture outcomes directly from members themselves.

Nudging behavioral health out of the data-free zone

Too often, behavioral health hovers dangerously in the data-free zone as it lacks an independently agreed-upon set of outcome measures. What measures do exist are imposed either by payers or providers themselves—aligning more to institutional biases than what matters most to patients. The result: a lack of comparison across geographies that perpetuates the status quo. Subsequently, we resort to activity measures as inadequate proxies for outcomes.

Following Professor Michael E. Porter’s definition of outcomes as what really matters for patients, ICHOM (International Consortium for Health Outcomes Measurement) endeavors to work with international experts to systematically generate standard sets of outcomes for groups of conditions. In 2015, ICHOM published a *Depression and*

Anxiety Data Collection Reference Guide that Beacon endorses.[27] This guide focuses on patient-centered results, applying internationally agreed-upon methods, including case-mix adjustment for specific risk factors and stratifying the outcomes by major treatment types. The list of outcomes includes the following:

- PHQ-9: Patient Health Questionnaire-9
- GAD-7: Generalized Anxiety Disorder-7
- SPIN: Social Phobia Inventory
- MI: Mobility Inventory for Agoraphobia
- IES-R: Impact of Event Scale—Revised for Post-traumatic Stress Disorder
- PDSS-SR: Panic Disorder Severity Scale
- OCI-R: Obsessive-Compulsive Inventory
- WHODAS 2.0: World Health Organization Disability Assessment Schedule 2.0

The impact of effective integrated care models will be reflected not only in improved behavioral measures but also in enhanced screening and improved medical outcomes, such as HbA1C, blood pressure, lipid profile, CD4 counts and HIV viral loads.

The systematic capture of outcomes across populations isn't easy. It requires technical expertise and the ability to exchange medical and behavioral health information within and across health systems. While many IT platforms may lack capacity to track symptoms in treating to target, and assessing progress in achieving goals, this capability is no longer a "nice to have". Insufficient focus on the infrastructure required will mean efforts at collaborative care, and ultimately integration, fail.

4. Evidence-Based Care

The promise of collaborative care is to offer patients treatment where there is credible research evidence to support its efficacy in treating the target condition. Knowing what works—and what doesn't—helps to inform care team members about treatment modalities and adjustments to those modalities.

However, mental illness has a complex etiology. It is the least evidence-based area of health care. Within the biopsychosocial framework, understanding of the molecular biology of neuropsychiatric disorders and deep-rooted economic and social risk factors—such as poverty, unemployment and abuse—are limited.

For example, despite known risks of serious side effects in antipsychotic use in older adults, the percentage of people older than 65 treated with antipsychotic medications increases with age. More than 75 percent of seniors receiving antipsychotic medication in 2010 had no documented clinical psychiatric diagnosis during the prescribing year.[28] Among those who did have a diagnosed mental disorder and/or dementia, nearly half of the oldest patients had dementia, despite evidence of limited efficacy and Food and Drug Administration warnings that antipsychotics increase mortality in people with dementia.[29]

However, contrary to any misperceptions that behavioral health care is just about prescribing, medication therapy is only ever part of the answer. A range of evidence-based psychotherapies are proven to work across a range of settings, including Problem-Solving Treatment, Behavioral Activation and CBT.

Regularly updated guidelines from the American Psychiatric Association (APA) and the American Society of Addiction Medicine synthesize the evidence base and therefore must be followed. However, there are other factors that can inform decision-making. For example, when we ask people with mental health problems what outcomes matter most to them, employment is at the top, with housing important as well. Sixty to 70 percent of people with serious mental illness would like to work in a competitive environment, yet 85 percent of those in publicly funded plans are not doing so. Less than 25 percent of people with serious mental illness receive any kind of vocational assistance, and only a fraction has access to supported employment.[30] However, the evidence base shows that supported employment programs are a structured approach to helping people with disabilities participate as much as possible in the competitive labor market, working in jobs they prefer with the level of professional help they need.[31]

> “Less than **25 percent of people** with serious mental illness **receive any kind of vocational assistance.**

Housing provides another example of a critical outcome for people with SMI. *Housing First* is a program that moves homeless people immediately from the streets to shelters or their own apartments.[32] If we follow the evidence base by applying the programs that make a difference, such as employment and housing, as well as measure their outcomes, then we can point to the success of holistic, integrated care.

How do we know if care is working?

The only way we will know if the treatments are effective is to ask. Rather than wait months for the next specialist appointment, in the collaborative care model, follow-up contacts are indicated weekly or every other week during an acute treatment phase. The telephone is an underutilized tool that care managers can readily use to check the following:[4]

- Quality of life
- Adherence to medications
- Side effects to medications
- Satisfaction with treatment
- Behavioral activation
- Symptoms while in remission

Clear criteria exist for when an individual needs to see a psychiatrist, as follows:[4]

- Is severely depressed (PHQ-9 score ≥20)
- Fails to respond to treatment
- Has complicating mental health diagnosis, such as personality or substance use disorders
- Is bipolar or psychotic
- Has current substance dependence
- Is suicidal or homicidal

In the collaborative care model, the evidence base shows care management should not be continued in perpetuity. Care management for people with depression typically lasts six to 10 months in duration, until the patient is substantially improved as defined by a score of PHQ<10 and PHQ-9 reduced by at least 50 percent.[4]

Once an individual is in remission, he/she remains at high risk of relapse. Consequently, the individual and his/her family members should be involved in co-creating a relapse prevention plan. Thereafter, care managers or providers can follow up with the individual monthly, usually by telephone or in a maintenance group, to gradually titrate down the frequency and intensity of touch points with professionals.

The goal of the relapse prevention plan is to enable patients to identify and track their own symptoms of mental illness, potentially using one of many self-tracking tools that are emerging, such as *uMotif.*[33] Self-monitoring builds engagement, resiliency and enables earlier interventions if and when symptoms recur. If symptoms recur, then the individual may need to be reassessed. A prevention plan also captures what worked last time for the individual to get better, focusing on those successful interventions, as well as what to do when symptoms recur.

5. Accountable Care

Let's talk about the money

The final pillar of the collaborative care model is about the financing of accountable care and integration. The U.S. behavioral health system is currently financed through a patchwork of payers, including state and county governmental units; the Medicare and Medicaid programs; private, commercial health insurers; patient out-of-pocket expenditures; and various smaller public and private programs.

The prevailing reimbursement methodology across all payers remains fee-for-service (FFS). This model maximizes the production of services through the number of visits and discrete transactions, incentivizing clinicians to work incredibly hard exclusively with individual patients, without access to family members and other health care providers who can provide a functional and longitudinal perspective. Yet, the reality too often is that each patient is treated as a uniquely special case for whom the "wheel" must be reinvented, leading to wasted human capital. Further, this approach has inadvertently perpetuated services that may or may not be evidence-based or effective. In this model, reimbursement is not linked positively or negatively to the actual outcomes of care.

> "Integration is about **more than just putting all of the dollars in one place.**

Integration is about more than just putting all of the dollars in one place. Indeed, the multiple touch points in integrated care, such as care coordination, phone consultation and more than one medical visit per day, rapidly become unsustainable if financed solely through a FFS model. Additionally, according to recent analyses by Milliman, initial investments at delivering integrated care are required by providers, yet the savings are generally realized on the payer side over an extended time period of three to four years.[7] Although the model is focused around improving behavioral health care, the bulk of savings is realized through pharmacy, medical inpatient and outpatient expenditures. As such, demonstration programs for integrated care have proven difficult to maintain once research funding ends.

> “**Integrated care calls for a different reimbursement model**, one that is more aligned to the value of care provided.

Therefore, integrated care calls for a different reimbursement model, one that is more aligned to the value of care provided. Several alternative reimbursement models to FFS exist. For example, monthly case rates or bundled payments can be applied to pay for such services as care management and psychiatric case reviews or consultations. Similarly, other forms of value-based payments (VBPs) can be deployed, such as capitation, episode-of-care payments and pay-for-performance incentives to catalyze and support integrated care efforts. For safety net populations, the implementation of a collaborative care model has shown significant clinical outcome improvement through the adoption of a pay-for-performance incentive for follow-up and intensifying treatment.[3] In short, there is no single right answer to VBPs. There are pros and cons to each payment model. The chosen model will therefore depend on a range of factors, including pre-existing arrangements and the specific challenges inherent in the local context. However, service redesign to support integration cannot take place in a sustainable way without concurrent payment reform. Whatever financial arrangement is brokered, there will be a need for risk adjustment and to make provisions for outliers. Any accurate costing begins with a comprehensive mapping of all the care processes involved.

As we transition towards reimbursing for value (outcomes) in mental health, this inevitably steers the conversation and system of care towards addressing the social determinants of health. For example, failure to address the housing and social needs of people with mental illness will act as roadblocks in the path to recovery.

In summary, VBP offers a route towards reimbursing more of the evidence-based interventions described earlier, such as care coordination activities, online therapies, supported employment and the inclusion of peers on integrated care teams. Many of these interventions have a growing evidence base, but no billing codes, which stalls current reimbursement efforts. To mitigate this problem, we support the APA’s recent call to develop specific payment codes for collaborative care.

Invite behavioral health to the ACO table

Underpinning this final pillar in the collaborative care model is the question of how behavioral health fits into the emergent Accountable Care Organizations (ACOs). The term “accountable care” points to the laudable three-part aim of Don Berwick’s Triple Aim, which the collaborative care model reinforces through the collective application of the model’s five pillars. Specifically, the model improves system functioning, patient outcomes and patient and provider satisfaction, as well as to help reduce health care costs.[4] By doing so, it satisfies the

Triple Aim's important three objectives:[34]

1. To improve the quality of care
2. To provide better health for populations
3. Lower expenditures

Despite the clear evidence—and first-hand experience of all clinicians—that medical and psychiatric patients have a high prevalence of comorbidities, too little thought has been given to the role that behavioral health plays in ACOs and how it can contribute to the above three goals. As discussed, the overall costs of care are disproportionately high on the medical side, which requires financial incentives and reimbursement to be organized in a different way. This imbalance is because, in all market segments, persons with treated psychiatric or substance use disorder typically cost two to three times more on average than those without a behavioral health condition.[1] An IMPACT study on the effect of collaborative care for older, depressed adults with cardiovascular disease revealed that the risk of a cardiovascular event was cut in half.[15] Therefore, investment in behavioral health is critical to offset medical costs.

In short, behavioral health must have a seat at the table in the development of ACOs to foster from the onset a productive partnership between medical and behavioral health providers. Where this has been done well, the shared vision and financial model have led to a step change in addressing individuals' holistic needs, including housing, food, employment, engagement with the education system, and improved coordination with state agencies.

Too often, the improved overall progress against the Triple Aim demonstrated by leading ACOs has not translated to corresponding improvements in behavioral health. New research examining the effect of ACOs on the delivery of behavioral health care suggests their impact is negligible as illustrated by a recent study of the Alternative Quality Contract (AQC). In the AQC, established by Blue Cross Blue Shield of Massachusetts in 2009, providers were compensated based on their ability to meet certain quality metrics. Only two of the 64 quality measures related to mental health.[35] Therefore, change to mental health did not "meaningfully" affect the overall metrics, or scoring, and little progress was subsequently made with behavioral health integration. This lack of progress was to such an extent that members with diabetes and cardiovascular conditions, as well as behavioral ill health, improved less in the AQC contract than like members in non-AQC contracts.

One implied failure of the AQC, therefore, lies in not effectively applying the principles of the collaborative care model's fifth pillar—tying mental health to accountability, incentivized through reimbursement. Part of the reason for this outcome is that about half of the overall savings from the AQC came from referrals to lower-cost providers—a strategy less viable for mental health, given the shortage of available clinicians accepting insurance.

As a payer, managing behavioral health is integral to promoting accountability through reimbursement, as some markets have already recognized. For example, California, Northern Illinois and Florida are all relatively mature ACO markets that have provider-led reimbursement models. Specialty managed behavioral health organizations (MBHOs) in these markets are augmenting the leading systems' lack of behavioral health expertise, particularly regarding value-based payment models. Such an approach means that the necessary investment in infrastructure to systematically track both the quality and outcomes of mental health care provided can occur, demonstrating MBHOs' value in driving an evidence-based approach at scale and delivering against VBP.

Integration needs to accelerate for the SMI

The collaborative care model operates fluidly with other community-based resources. For example, if an individual with SMI is seen in a primary care setting, they may intermittently require referrals to additional services, such as Intensive Outpatient Programs (IOP) or Assertive Community Treatment. The care manager will facilitate these referrals and remain accountable to ensure that people don't "fall through the cracks" and/or are lost to follow-up.

Although many people with SMI can and are treated in primary care settings, a substantial proportion of people with SMI will continue to require specialty expertise. Evidence suggests that people with severe illness, such as major depression, may achieve better outcomes in an enhanced referral model compared to continued treatment in diverse primary care settings, highlighting the role for specialty referral even in integrated models.[36]

The following section addresses what integration looks like for people with SMI who require specialty care and whose primary point of contact is not primary care. Whether talking about specialty or primary care, it is essential to ensure that each level of integrated care delivery is fluid so people don't get habitually stuck in any one level of care.

What "integration" means for people with SMI (serious mental illness)

Despite ongoing efforts at achieving integration and reducing stigma, people with SMI remain the most likely group to receive suboptimal care in primary care settings.[37] Even when people with SMI are engaged with care, as few as 7 percent actually receive evidence-based practices.[18] Such individuals continue to live on the fringes of our communities, families and society more broadly. Without a specific targeted approach from a health care perspective, they are disconnected from the larger system of care.

Patterns of accessing care differ as well. A comparison of health care utilization in Massachusetts reveals that people with SMI access emergency department care six times more often, and primary care half as often, when compared to people without SMI.[38] When asked why, individuals with SMI report they have trouble getting to appointments; feel uncomfortable disrobing in front of doctors; feel doctors do not really listen to them; and crowded waiting rooms make them nervous. Compounding this view is that many PCPs do not feel confident managing people with SMI. PCPs may not recognize the early signs of mental illness, and if they do, lack opportunities to discuss shared care plans with specialty mental health colleagues.

Thus, even for the minority of primary care sites with a collaborative care model, individuals with severe mental health problems are likely to have their dominant relationship with specialist mental health providers. Therefore, in an era of integration, the role for specialty care unequivocally remains. The five core principles of collaborative care are all critical tenets of delivering high quality care for individuals with SMI. However, there are some important differences in the delivery model of care itself as follows.

Listed below are the core characteristics of an IPU:

Features of an Integrated Practice Unit
1. An IPU is organized around people with SMI and/or specific mental health conditions, such as substance use disorders or autism.
2. Medical and behavioral health care is delivered by a dedicated multidisciplinary team of clinicians and non-clinicians who are devoted to the specific medical condition.
3. Providers see themselves as part of a common organizational unit.
4. The team takes responsibility for the full cycle of care for the condition, encompassing outpatient, inpatient, and rehabilitative care, and supporting services (such as nutrition and social work).
5. Patient education, engagement and follow-up are integrated into care.
6. The unit has a single administrative and scheduling structure.
7. To a large extent, care is co-located in dedicated facilities.
8. A physician team captain or clinical care manager (or both) oversees each patient's care process.
9. The team measures outcomes, costs and processes for each patient using a common measurement platform.
10. The providers on the team meet formally and informally on a regular basis to discuss patients, processes and results.
11. Joint accountability is accepted for outcomes and costs.

Source: The Strategy that Will Fix Health Care, *Harvard Business Review* 2013[39]

HERE-FOR-YOU PROGRAM^{SM}

One real-life example of a community-based IPU for people with SMI is the Here-for-You Program in Massachusetts between Neighborhood Health Plan and Beacon launched in early 2016. This program is an innovative care coordination model specifically designed around the needs of 10,000 adults with bipolar affective disorder and/or psychotic disorders. Rather than being purely a medical model, this program emphasizes providing support for individuals with SMI as a means to overcome the psychosocial stressors that inadvertently prevent them from accessing appropriate health care services. Specific interventions include coordinating with services that provide housing, food and transportation.

Traditional funding mechanisms do not capture the value that this kind of integration provides. Therefore, this kind of integrated approach requires a variation from existing funding models. In this specific example, the average total medical expense for the population is ~$1,250 PMPM (per member per month). For those in the most medically complex risk category, the costs exceed $5,000 PMPM.

In the new integrated model, funding is converted to a monthly case rate that includes care coordination and specific behavioral health specialist care. Upon meeting certain quality outcomes metrics, eligible providers share in any resultant savings related to total medical expenditure. This approach to shared financial incentives between medical and behavioral health care incentivizes activities that promote integration. It leverages the specialty capacity of the behavioral health system to serve a population that it knows best and where consumer engagement is greatest.

The full integration of administrative data for care management purposes is essential to this approach, which is where specialty behavioral health management steps in. Behavioral health organizations, such as Beacon, bring core managed care capabilities, including the leveraging of information systems, quality management/utilization management functions, expertise in building and managing provider networks, and proactive outreach to members.

Value-based health care delivery: Integrated Practice Units (IPUs)

To organize optimal integrated care that meets the needs of people with SMI, integrated comprehensive care should be delivered by dedicated multidisciplinary teams in SMI Integrated Practice Units (IPUs) at individuals' principal sites of care in the community. As defined by Porter and Lee, an IPU is a dedicated team comprised of clinical and nonclinical personnel who provide the full cycle of care for a patient's condition.[39] In most cases, behavioral health outpatient providers and/or community mental health centers will form the organizational basis of an IPU as these providers are the main points of contact for many people with SMI today. It is important to note that the multidisciplinary nature of the IPU team is also well positioned to treat the often non-clinical needs of those individuals with substance use disorders, such as housing or employment support.

In the absence of an IPU as an organizing principle, an individual with SMI risks pinballing around the system in an uncoordinated fashion, leading to poor outcomes; communication may be unreliable between different health and social care teams caring for the same patient. Often, the result is institutionalization for the seriously mentally ill when a crisis occurs, but an IPU can help avoid unnecessary institutionalization. As the IPU is solely dedicated to meeting the needs of people with SMI, or other specialist groups of behavioral health conditions (i.e., substance use disorders or autism), the IPU gains unique expertise in this domain and subsequently achieves better outcomes for individuals and their families.

Thus, the major advantage of IPUs is that improved expertise and coordination of care for patients in community settings avoid prolonged hospitalizations and/or prevent initial inpatient admissions. An IPU model ideally has strong pre-existing (affiliated) relationships with community supports critical to recovery, including: employment, housing, the justice system, and state and social service agencies. Given the high rate of comorbid substance use disorders, alliances also exist with substance use disorder outpatient and diversionary services for this population.

> “An IPU is a dedicated team comprised of **clinical and nonclinical personnel** who provide the full cycle of care for a patient’s condition.

The multidisciplinary IPU team

Essential IPU team members for severe and complex behavioral health conditions include both psychiatrists and psychologists—psychiatrists to recommend appropriate medication, according to evidence-based guidelines, and psychologists to provide psychological assessments and interventions. However, the key point people in any IPU are the care managers, who may be trained social workers, community health workers, licensed mental health clinicians or psychiatric nurses. Their role is to be primarily responsible for evaluating each individual’s needs, bringing together the resources, and medical as well as mental health providers, necessary to achieve the holistic goals of each individual’s care plan. Critically, this role includes responsibility for engaging patients and their families—for instance, through education and counseling. Given the risk that people with mental health problems are or will become socially isolated, an important role exists for people with “lived experience” (people with mental health problems themselves) to provide peer support. Such peer networks, or communities, can be of immense benefit online as well as offline.

The ability to have formal and informal interactions through colocation in an IPU encourages team members to adopt a goal of working together to do whatever is needed to help a patient, rather than just fulfilling obligations related to their subspecialty. Systems for proactively reaching out to patients between visits, checking on their status, regulating their medications, and addressing psychosocial issues are more effective when key team members are face-to-face on a daily basis, a capability not present in most primary care settings.

Given the complexity inherent in such populations, the multidisciplinary team based in the IPU should be set up so that clinicians have flexibility in their scheduling, spending a longer time per appointment with each person when necessary. This flexibility enables challenges related to comorbidities, polypharmacy and the social determinants of health to be addressed.

Treat physical health needs in mental health settings

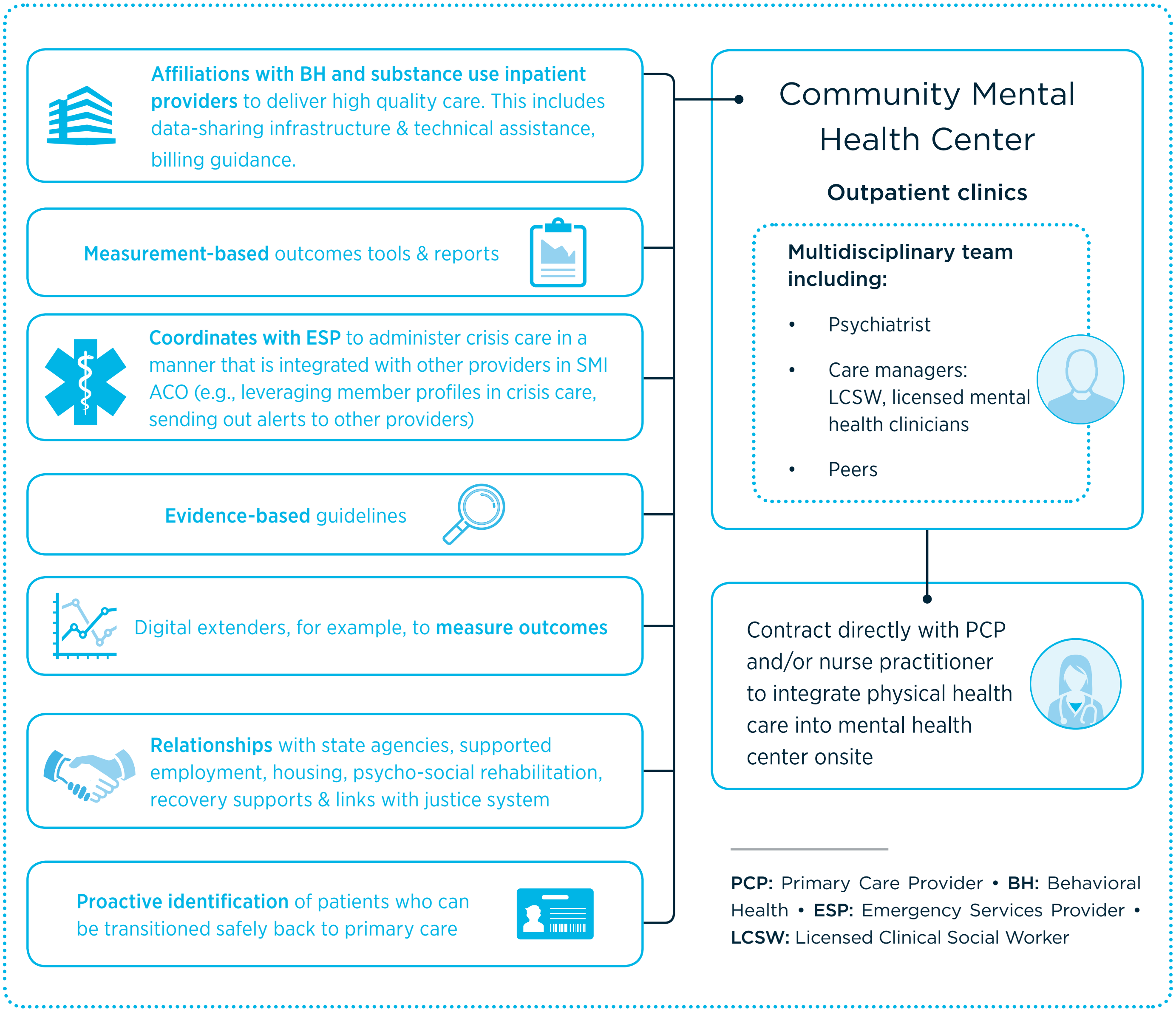
As discussed, the majority of excess deaths in the SMI population are due to medical illnesses, in particular cardiovascular disease, respiratory illness and cancer.[40] Additionally, people with psychotic disorders have been identified as less likely to receive routine cancer screening, standard diabetes care, treatment for arthritis, and post-stroke treatment. To address these unmet physical health needs, sometimes described as "reverse colocation", SMI IPUs should include dedicated nurse practitioners and/or be tethered to primary care clinicians.

Within IPUs, PCPS and/or nurse practitioners have a key role to play in medication reconciliation, chronic disease education and self-management support, as well as working closely with the individual's care manager on his/her person-centered recovery and crisis plan. Studies demonstrate this approach's considerable potential, particularly in reducing lifestyle risk factors. Recently, the Milbank Memorial Fund conducted an extensive literature search and reported on findings derived from 12 randomized controlled trials.[37] In general, care enhanced by trained nurse care managers improved mental health-related outcomes and the use of preventive and medical services, as well as reduced cardiovascular risk factors in individuals with diabetes. However, other efforts have had mixed results. For example, an evaluation of SAMHSA's Primary and Behavioral Health Care Integration program demonstrated improvements in indicators for diabetes, hypertension, and dyslipidemia, but no improvements in smoking or obesity.[41]

In summary, the subgroup of people with SMI and/or substance use disorders forms a distinct segment of the population that requires, and will benefit from, continued specialist expertise. Such individuals may not optimally engage in a primary care setting—even when fully integrated. From an ACO perspective, a specialist IPU model for SMI essentially forms "an ACO for SMI within an ACO". (See Figure 3 for a graphic of an SMI ACO.) As the earlier example of AQC illustrates, the absence of identifying and reimbursing for this population's distinct needs and outcomes risks a decline in recent decades' progress in improving the quality of care for this cohort.

Figure 3:
Integration for people with SMI (serious mental illness)

Beacon supports an SMI ACO through linkage to a diverse range of services



Affiliations with BH and substance use inpatient providers to deliver high quality care. This includes data-sharing infrastructure & technical assistance, billing guidance.

Measurement-based outcomes tools & reports

Coordinates with ESP to administer crisis care in a manner that is integrated with other providers in SMI ACO (e.g., leveraging member profiles in crisis care, sending out alerts to other providers)

Evidence-based guidelines

Digital extenders, for example, to **measure outcomes**

Relationships with state agencies, supported employment, housing, psycho-social rehabilitation, recovery supports & links with justice system

Proactive identification of patients who can be transitioned safely back to primary care

Community Mental Health Center

Outpatient clinics

Multidisciplinary team including:

- Psychiatrist
- Care managers: LCSW, licensed mental health clinicians
- Peers

Contract directly with PCP and/or nurse practitioner to integrate physical health care into mental health center onsite

PCP: Primary Care Provider • **BH:** Behavioral Health • **ESP:** Emergency Services Provider • **LCSW:** Licensed Clinical Social Worker

> “Psychiatrists of the future will have to **shift professional roles** in line with the evidence base surmised in this paper.

Conclusion

Too often today, behavioral health care is either too difficult to access or is not delivered according to evidenced-based care guidelines. This paper sets out a roadmap for delivering care models that make it easier for all practitioners, both primary care and specialist behavioral health, to graduate from practicing in isolation to delivering care as part of a highly effective “pit crew”. Psychiatrists of the future will have to shift professional roles in line with the evidence base surmised in this paper. To be successful will require a culture of shared accountability, not just between payer and providers, but also between physical and behavioral health providers and broader system stakeholders. Furthermore, the evidence base has now substantiated the undeniable role for new technologies as treatment extenders in behavioral health. Ultimately, integration matters because it delivers the best outcomes for people and their families. While the collaborative care model, as set out in this paper, is not the only approach to integration, the evidence shows it is the gold standard. The model breaks down traditional boundaries and definitions of roles and responsibilities. It is tantamount to changing delivery models—which makes it hard and explains why widespread adoption has not yet taken place.

In spite of the challenges to achieve integration, both for the collaborative care model and in specialist care settings, it is a path that the industry needs to pursue. More specific responsibilities for stakeholders can be found in an Addendum to this White Paper. However, there is a paucity of research regarding how integration is optimally achieved in rural areas and by small-to-medium primary care practices.

To that end, while we are committed to relentlessly pursuing an evidence-based integration agenda, we know that only 10 percent of health outcomes are determined by the delivery of health care services.[18] Most of health is determined by environment and habits, such as housing and nutrition. Therefore, to empower our members to live their lives to their fullest potential, we care as much about where they live, whether they have something to do during the day, and whether they have someone to talk to—as we do about what medication they are being prescribed and whether they are compliant. Indeed, the goal of integration is to treat individuals holistically.

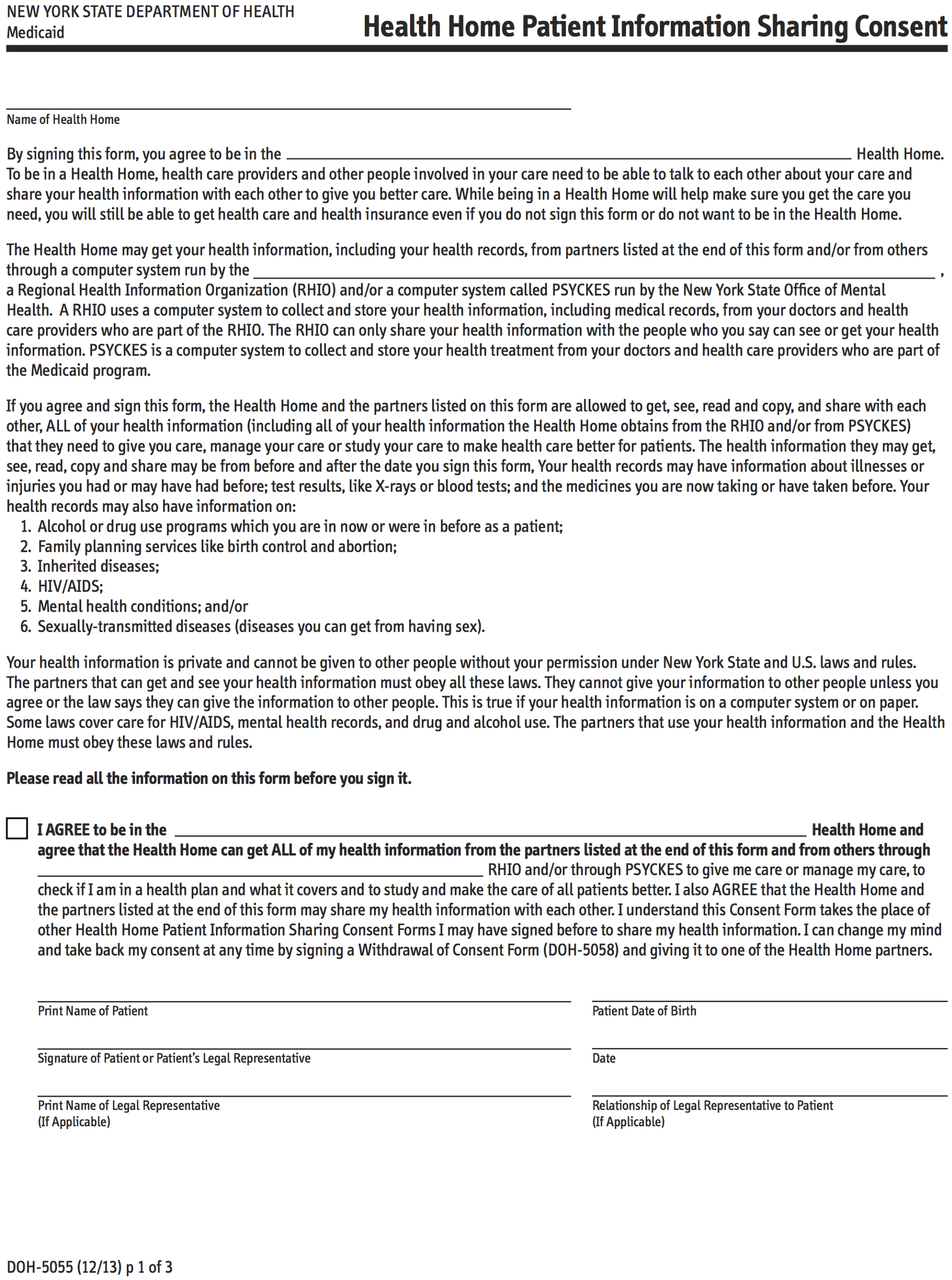
The purpose of this White Paper, consequently, is to synthesize the evidence for integrated care and to share Beacon Health Options' philosophy on how the system can best improve outcomes for the people we serve. As an MBHO, our efforts and expertise are focused specifically on the role of behavioral health. Done correctly, new delivery and payment models, such as ACOs, offer further impetus for mental health integration. However, a failure to acknowledge the unique nature and demands of the behavioral health sector risks stepping backwards. Subsequently, it is time to preemptively advance a coordinated integration strategy in partnership with all industry stakeholders and the people we serve.

APPENDICES

As shown below, PHQ-9 assists with identification of depression and diagnosis through tracking nine core symptoms over time. It is easy to use, can be done over the phone and is available in multiple languages.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying a	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	For Office Coding __0__ + ______ + ______ + ______ =Total Score: ____________			

Source: Adapted from Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine,* 16:606-13, 2001



NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

____
Name of Health Home

By signing this form, you agree to be in the ____ Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the Health Home.

The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the ____ , a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health treatment from your doctors and health care providers who are part of the Medicaid program.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO and/or from PSYCKES) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form, Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions; and/or
6. Sexually-transmitted diseases (diseases you can get from having sex).

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that use your health information and the Health Home must obey these laws and rules.

Please read all the information on this form before you sign it.

☐ **I AGREE to be in the ____ Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through** ______________________________ RHIO and/or through PSYCKES to give me care or manage my care, to check if I am in a health plan and what it covers and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

______________________________ Print Name of Patient	______________________________ Patient Date of Birth
______________________________ Signature of Patient or Patient's Legal Representative	______________________________ Date
______________________________ Print Name of Legal Representative (If Applicable)	______________________________ Relationship of Legal Representative to Patient (If Applicable)

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Source: New York State Department of Health. Health Home Patient Information Sharing Consent Form. http://www.health.ny.gov/forms/doh-5055.pdf. Accessed on 11/16/15.

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ABOUT BEACON HEALTH OPTIONS

Beacon Health Options (Beacon) is a behavioral health management company that provides behavioral health solutions for regional and specialty health plans; employers and labor organizations; and federal, state and local governments. Specifically, Beacon offers clinical behavioral health and substance use disorder management, an employee assistance program, work/life support, and specialty programs for autism and depression. From the most vulnerable populations, to our military and their families, to Fortune 500 employees and their dependents, we ensure full-spectrum, high-quality behavioral health care.

To meet Beacon's mission of helping people lives their lives to their fullest potential, Beacon draws on the evidence base to ensure that the services we support are holistic and person-centered, using robust data analytics to improve the delivery of that care. We partner with providers to help them both understand what meaningful, evidence-based care is—care that makes people healthier—and to support them in delivering it.

Facts about Beacon Health Options

- » Headquartered in Boston; more than 70 US locations and a London office
- » Nearly 5,000 employees nationally and in the UK serving more than 47 million people
- » 225 employer clients, including 45 Fortune 500 companies, as well as large and medium employers
- » Partnerships with 100 health plans serving commercial, FEP, Medicaid, Medicare, and Exchange populations
- » Programs serving Medicaid recipients and other public sector populations in 25 states and the District of Columbia
- » Services for 8.6 million military personnel, their family members, veterans and federal employees
- » Leader serving dual-eligible beneficiaries in six states
- » Accreditation by both URAC and NCQA

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