Integrating Care Of Body and Mind

JOHN MORRISSEY

The impact of mental health and other behavioral problems on someone's physical health is substantial and pervasive. So is the reverse: the impact of physical problems on behavioral health. That stark synergy of behavioral and medical status is the force pushing against any plans by health care systems to achieve better patient outcomes while managing and containing the costs of care.

A patient develops diabetes and, because he's also depressed, doesn't follow treatment instructions and gets unnecessarily sicker. Or he gets depressed because he developed diabetes — same medical result. Other chronic conditions similarly require a person to make an effort, and that ability is undermined by mental state. "The condition and the anxiety influence each other," said Carol Hartmann, director of behavioral and mental health for Ascension, St. Louis.

At the level of population health management — the core of value-based care delivery and increasingly a basis for reimbursement — the task is clear, said Dimitry Davydow, MD, MPH, medical director of behavioral health for CHI Franciscan Health, Tacoma, Washington. "Addressing the issue of behavioral health conditions is absolutely vital to making any gains in population health."

A prime example concerns the epidemic of obesity and associated chronic diseases such as diabetes, coronary artery disease and hypertension. Depression is a risk factor for developing all those conditions, said Davydow, and it also is a risk factor for becoming obese in the first place.

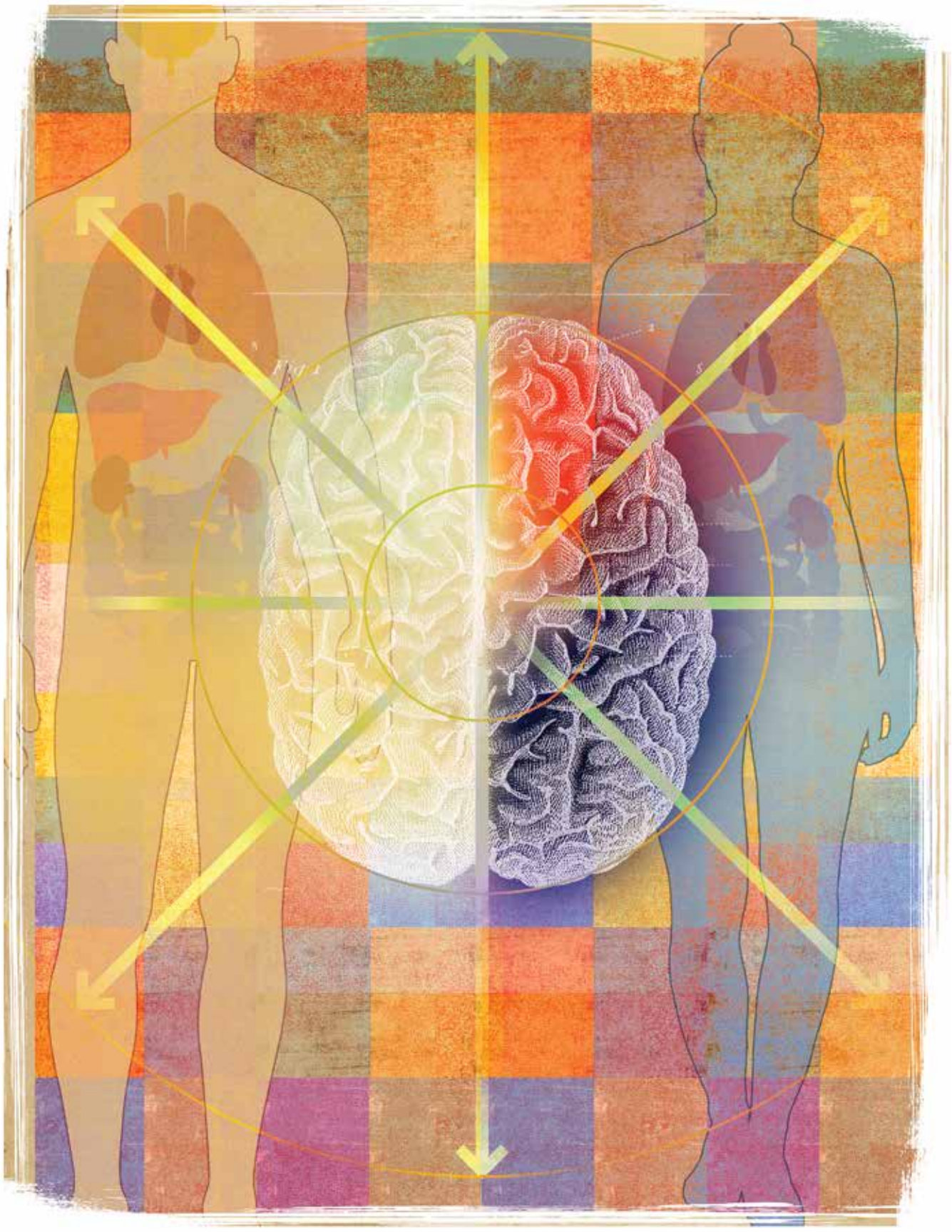
For people struggling with more burdening behavioral conditions, it's even more consequential. "We know that people with serious mental illness, like schizophrenia and bipolar disorder, on average die about 15 to 20 years earlier than people without those disorders," he said. Complications of heart disease, stroke and diabetes are the primary causes of early death for those with serious mental illness.

The separation between physical and behavioral systems of care is a long-standing obstacle, experts maintain. If a primary care physician suspects depression might be at work, he or she either tries to handle the mind/body episode alone or the patient gets a referral to a behavioral health specialist who will independently examine, at a later date, a disorder that might affect diagnosed medical problems.

The situation calls for both more behavioral expertise immediately, not later, as well as a way to bring that expertise close to the encounter, not at another place or another time. The answer making the rounds in health care is to integrate behavioral health and primary care.

PRIMARY CARE AND BEHAVIORAL HEALTH

For many years, depression has ranked as a leading worldwide cause of disability, according to annual research by the World Health Organization.[1] In 2017, it became the leading cause. The



impact can be felt at the physician group level every day, said Terry Mills, MD, medical director of St. John Clinic, Tulsa, Oklahoma, a ministry of Ascension.

According to multiple studies, he said, "Something like 20 percent of all the patients that a primary care office has on any given day have a diagnosable behavioral health issue, whether it was diagnosed or not. As I say to docs, if you saw 20 patients yesterday, unless you made four diagnoses or five diagnoses [of behavioral issues], you missed them — because they were there."

Yet the norm of practice, driven by financial influences, is 15 to 20 minutes per patient, and "that's just not the right structure to be effective in anything but the simplest behavioral health interventions," Mills said. With myriad medical conditions to diagnose and treat, as well as value-based performance metrics to meet, it isn't reasonable to expect primary care physicians to do all of that personally and add behavioral health too, he said. A team representing behavioral and physical health expertise has to be assembled and be complementary to each other.

Since 2013, St. John Clinic has phased in behavioral health specialists at 12 of its more than 50 clinic sites in and around Tulsa. It's one example of initiatives around the country to situate social workers, psychologists and licensed counselors in primary care. They are there either to mobilize for a handoff of a patient who a physician determines needs help with mental or emotional aspects of a physical problem, or to see patients before a physician gets involved, in situations that call for that initial approach to the encounter.

Though he doesn't have the statistical proof, Mills asserted that doctors practicing in the integrated settings have seen the difference it makes to have a behaviorist in the office. They are "very aware of patients that would have struggled and failed and been in the ED or been hospitalized and are [instead] doing better and having fewer adverse outcomes," he said. "Get the therapists and primary care doctors seeing each other every day and rubbing elbows, and amazing things happen."

MODELS OF INTEGRATION

The blending of physical care with behavioral can take different models, using various professionals and not always in the primary care office. (See sidebar page 13).

"It takes a fair amount of infrastructure and changing the way you think about things," said Susan McDaniel, PhD, director of the Institute for the Family, Department of Psychiatry, University of Rochester (N.Y.). A team available to provide support for patients to improve their health offers ready options for any particular case, "and sometimes you're going to need a little more of this and a little less of that," she said.

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Just as important as appropriate skills are availability and a common mindset. If a behaviorist isn't working in concert with others under a "shared mental model" of agreement among disparate pros about what the actions and goals should be, it can be hard to do what the patient needs, said McDaniel. The objective, she explained, is "a shared vision of what mind, body and spirit look like when they're coming together in a healthy way," and then working with patient and family to create that healthy context.

Ascension is working on models of integration in which social workers, clinical psychologists or health psychologists are meshed into primary care, said Hartmann. While there is some value in co-locating psychiatrists, the more inherent value is in co-locating social workers and psychologists who can be the entry point into mental health care. They can assess whether an intervention with a psychiatrist would be of benefit, such as when a drug is recommended that a primary care doctor is not comfortable prescribing, she said.

A collaborative care model developed by the University of Washington often involves a social worker or a nurse as a behavioral health care manager to address common behavioral conditions showing up in a primary care encounter, said Davydow. The care manager works with cli-

nicians on one hand and psychiatric consultants on the other.

Not every primary care setting can support such a tightly integrated contingent, operationally or financially, so the minimum objective is to introduce a behavioral consulting capacity in some way. If an office of behavioral specialists is nearby and takes referrals, it's better than not talking and working together, McDaniel said. But the distance still is a barrier, and behavioral expertise is likely to come in late.

The odds that a patient will follow through on an appointment to see a mental health professional elsewhere in the community are normally only about 30 percent, Mills said. For a referral to a partner down the hall: 80 percent.

EQUAL STANDING

Deployed effectively, behavioral health expertise can help get to the core of a person's suffering sooner and with a standing equal to physical care in importance.

Too often, a patient with vague complaints will undergo a series of inquiries into medical possibilities until the doctor is satisfied that the problem is not organic. Only then will the physi-

BLENDING PHYSICAL AND BEHAVIORAL CARE

Primary care clinics that include behaviorists can detect and respond to mental health issues along with medical problems. The reverse is also true. Behavioral health clinics can detect and begin to resolve physical problems that their clients aren't addressing.

As medical leaders push to integrate behavioral health care in settings of primary care, "there are also pushes on the other side, because a lot of folks with serious mental illness don't access primary care as often as other folks," said Dmitry Davydow, MD, CHI Franciscan Health medical director of behavioral health, Tacoma, Washington.

The only health care, and any kind of preventive care, that people with serious mental illness may get is in a specialty mental health care setting such as a community mental health clinic, Davydow said. The push for primary care integrated into behavioral health settings is so that those patients have some access to preventive medical care and early intervention for medical issues that can worsen.

A behavioral health specialist might have a hunch that the confusion a patient with mental illness is experiencing might not be anxiety-based, said Susan McDaniel, PhD, an expert at the University of Rochester's department of psychiatry. It might instead be medical, and an MRI would help determine that. Having a medical professional in the house would help confirm the hunch and set up the test, she said.

Since 2013, PeaceHealth has been working reverse integration into a behavioral health medical home, with each enrolled patient receiving the majority of care from a primary care physician and consultations from a psychiatrist, said Carla Gerber, manager of behavioral health services for PeaceHealth Oregon.

People with a combination of chronic pain, mental health problems and substance abuse have been seen at the behavioral/medical clinic, as have people with chronic health conditions complicated by mental health issues, Gerber said.

Intense efforts to prevent escalation of problems include seeing patients at home if need be, which helps make sure the ongoing intervention isn't interrupted or discontinued if patients have difficulty coming in for appointments. That has made a big difference in their ability to access care outside a hospital, she added.

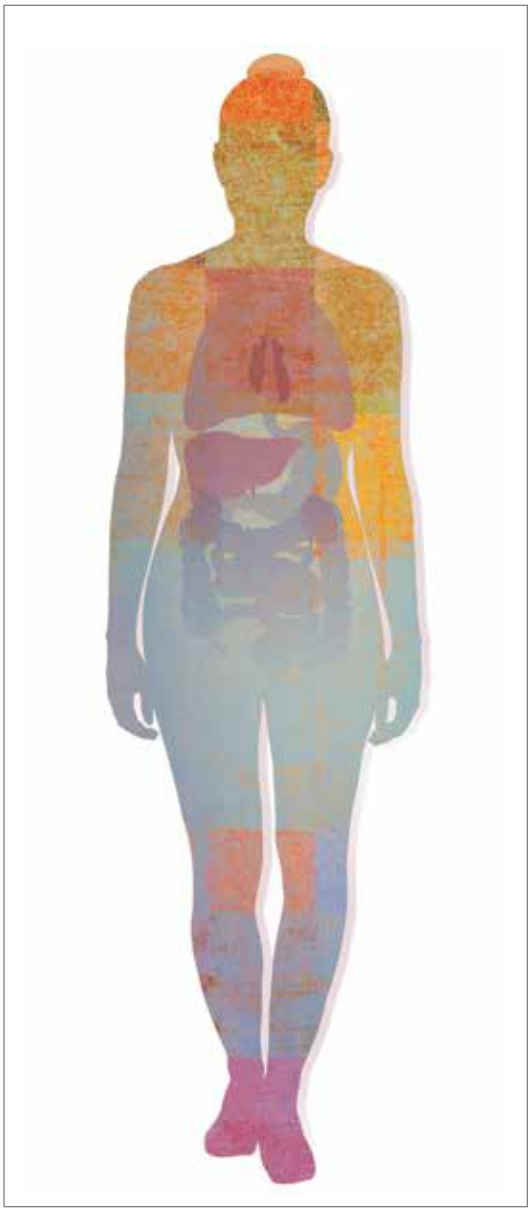
The reverse integration "dramatically reduced the overall cost of care," Gerber reported. "We increased costs for outpatient and primary care, but we reduced the cost of hospital-based care — emergency room and hospitalization — by thousands of dollars per month per patient." A study of patient status one year before and one year after being enrolled in the clinic recorded a 90 percent decrease in inpatient costs, and a total cost of care 75 percent lower during that study time frame.

PeaceHealth is now in the process of building seamless connections between specialty behavioral health care and the behavioral consultants in primary care, Gerber said. That's so anyone seen in primary care with behavioral health needs can get immediately into specialty care if his or her condition would be better treated there.

Actions can consist of a temporary consultation with recommendations back to the primary care location, or having a patient with co-occurring medical needs go to the behavioral health medical home if the behavioral needs are more serious than can be met through integrated primary care.

cian talk about stress or anxiety, McDaniel said. "Patients as a whole do not like that approach. It feels like you're saying, 'It's all in my head, you're not taking me seriously.'"

An integrated team changes that interviewing process, the questions coming from a range of angles so as not to give the impression that medical things are most important, she said. Instead, the physician or nurse practitioner will acknowledge not being sure of what's happening and will call in another staff professional introduced as someone who "knows how to work with patients before we really understand what the problem is." It may be a five-minute chat, then a return visit in a few days to talk at more length.



Some integrated practices schedule patients with a behaviorist at least annually. If there's a cancellation, the behaviorist is free to walk into any exam room without labeling a problem as psychosocial, because most problems have an element of that, said McDaniel. A medical director may decide that a patient needs a behavioral health approach first instead of a medical exam, further countering the assumption that the medical intervention drives everything else.

Within PeaceHealth's Oregon Network, an integrated approach uses "complex-care managers" in all clinics who are trained to work with physicians and behavioral health social workers to coordinate care for patients, said Richard Bennett, vice president of medical group operations. The managers also identify and manage sources of stress for patients, for example, family dynamics, financial difficulties or expectations at work.

Some social workers can have a practice role, assisting in therapy, while others concentrate on connecting patients to social services. Some clinics have both. That component of clinic structure is then integrated with chronic-care managers, all to build a team to help patients through whatever their issues are, whether the care is for body or mind, said Bennett.

MAKING IT ROUTINE

The stigma around mental illness can prevent patients from following through on recommended care, either because they are uncomfortable with the situation or they don't want to be seen getting that kind of care. A high no-show rate speaks to the mental condition itself, but also the fear that surrounds mental health as a whole, said Hartmann. When patients get a separate referral that they have to get in their car and travel to, for example, "they tend to talk themselves out of it," said Hartmann.

In an integrated setting, however, "having mental health care available normalizes it," she said. Patients look to their primary care doctors to be the care expert; having behavioral care accessible through primary care makes it part of that relationship.

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The objective is to make behavioral health "a routine part of health care instead of something entirely different," said McDaniel. The practitioners are right there, and it reduces stigma because a patient is just going to the doctor. "It's not like you have to sneak into the mental health center or your therapist's private office."

This integrated arrangement "in no way, shape or form detracts from the primary care provider's foundational role as the *de facto* mental health system in the country," Mills emphasized. "It just gives primary care physicians another tool to use when they find problems."

Those physicians still remain involved, directing care and doing recommended mental health screenings, but instead of either a referral across town or a prescription — their only options up to now — the integration is enabling more options and better patient engagement, Mills said. "When the behaviorist is part of the primary care team, whether making a hot handoff or not, it's someone that clearly the doctor knows, trusts, understands, has worked with, has a relationship with."

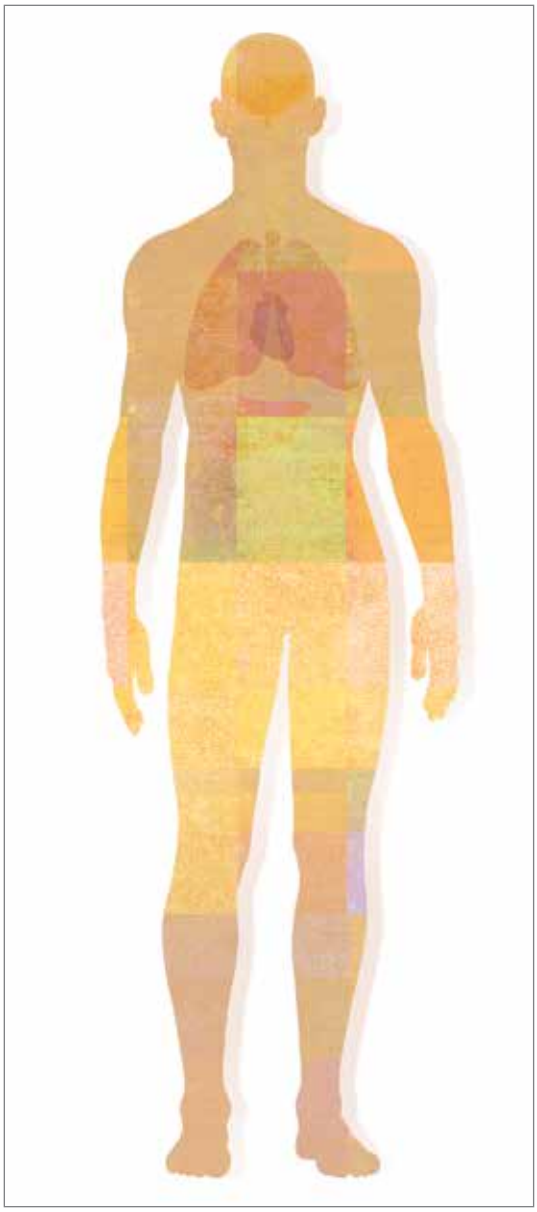
"It doesn't overturn decades of stigma," Mills said, "but it beneficially removes it from being a factor, because it all happens within the medical practice."

Primary care's *de facto* status isn't expected to change, and it likely will be leveraged more than it already is. Most areas of the country have a shortage of behavioral specialists, and integrated practices are meant to increase access to at least some level of evidence-based mental health care and extend its reach, said Davydow.

Adds Hartmann of Ascension: "We need our primary care docs, who are already delivering mental health care, whether they call it that or not, to be able to assess and diagnose mild to moderate depression and treat it at the primary care level."

INTEGRATED PRIMARY CARE

For St. John Clinic and PeaceHealth, incentives to manage populations already are long-standing from government-led clinical and financial performance programs. That makes their integrated behavioral care initiatives crucial to achieving



patient outcomes that meet targets for shared savings and definitive quality.

The Tulsa area is one of seven regions that participated in Comprehensive Primary Care (CPC), an initiative by the Centers for Medicare and Medicaid Services that ran from 2013 through 2016 and paid bonuses to practices, including St. John Clinic, that better coordinated care for their patients and met targets on quality and care costs. A sequel, CPC+, which started in 2017, requires practice redesign to be able to operate under comprehensive payments, performance-based incentive bonuses and care management fees.

Meanwhile, the Oregon Medicaid program in 2012 shifted all funding for both physical and mental health to newly organized units called coordinated care organizations and left it mainly to them to figure out how to organize an alternative payment arrangement based on showing improvements in quality and cost effectiveness. PeaceHealth has been a major participant in those units.

Lessons learned in the integrated primary care settings in Oregon have been spread throughout the PeaceHealth care network, said Bennett. The standard practice of screening everyone for signs of depression at Oregon sites in Eugene, Springfield and Cottage Grove "has been so successful that it's been rolled out over the last year to all primary care from here to Alaska," he said.

Hartmann initiated a patient navigator for behavioral health services while working for AMITA Health, a nine-hospital Catholic system in suburban Chicago that joined Ascension in 2012. She said it made sense for behavioral health in the same way that medical services were deploying navigators to get patients the information and access to services they need.

In February 2017, Ascension announced it will expand behavioral health care in all of its markets and incorporate it more comprehensively into ongoing work in population health management. Behavioral health is listed as one of Ascension's

CRITICAL ILLNESS BRINGS EMOTIONAL STRESS

Post-traumatic stress disorder is usually ascribed to the horrors of a battlefield, but PTSD also can result from life-threatening hours or days spent in an intensive-care unit, ganging up with depression to present serious obstacles to medical recovery.

"By definition, anything that threatens your life is an extremely stressful event," said Dmitry Davydow, MD, a psychiatrist with a subspecialty in psychosomatic medicine, the interface of mental health and medical conditions. Davydow's research indicates that the emotional stress of fighting and surviving comes at a physiological price, including "what it does to the various stress hormone levels and other 'fight or flight' hormone responses," he explained.

An essay by Davydow published in a 2015 issue of *Critical Care Medicine* noted that then-current research "reinforces that substantial PTSD symptoms are alarmingly common in critical illness survivors," and that the symptoms are associated with worse health-related quality of life.

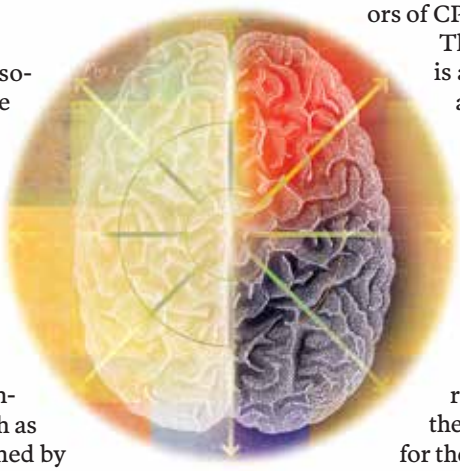
Those findings only further argue for mental health care as a big piece of the overall effort to improve individual outcomes and population health instead of keeping it separate, Davydow asserted. A cascade of mind/body factors can bring on the costly, harrowing disorder.

People already dealing with a history of depression or anxiety are at much greater risk of developing chronic medical conditions that, in turn, put them at greater risk of life-threatening illness. The combination of life threat and mental fragility can trigger PTSD.

Davydow explains the post-traumatic stress can be "related to having a lot of difficulty with experiences that actually happened in the course of having a critical illness — remembering how frightening it was to be on a mechanical ventilator — or even remembering things that didn't actually happen but they thought were happening at the time, because they were confused or delirious, and were incredibly frightening." The flare-ups will negatively affect the ability to recover, he noted.

Recovery-sapping behavioral reactions can affect any serious surgical intervention, not just the experience itself, but post-procedure feelings about life in the aftermath that can drive patients into depression. At Ascension Healthcare, musculoskeletal specialists are now doing pre- and post-op mental health assessments, said Carol Hartmann, director of mental and behavioral health. Patients assessed as being under mental duress are directed immediately to professionals to help get them through it, so recovery includes not just rehabilitation of the body but also the mind and spirit, she said.

four clinical service lines, along with cardiology, oncology and musculoskeletal care.



ADDING EXPERTISE

As payment mechanisms associated with the Medicare Shared Savings Program, CPC and now CPC+ have become driven increasingly by clinical quality of care and outcomes metrics, providers are faced with solving any and all barriers to achieving those aims, said Mills of St. John Clinic. Screening metrics central to behavioral health, such as for depression, "are now owned by primary care, whether you feel trained to do that well, you have time to do that well, or you're comfortable with it."

When patients being cared for under these arrangements aren't meeting their treatment goals, "we know a large portion of those have mental health comorbidities," he said. For example, the research on cardiovascular health is clear that about 4 in 10 people with congestive heart failure have concurrent depression, and those patients have worse outcomes. One response to that might be to build a behavioral component into a dedicated heart clinic, "but it's more of a natural and philosophical fit with primary care," Mills said.

Those realities led the clinic to hire two licensed practical nurses, a licensed social worker, a doctoral psychologist and a licensed marriage and family therapist to work among 12 primary care clinics, either for an immediate handoff if the professional is on site or alerted in their electronic inbox to phone in, if working at a nearby clinic site. The clinic plans to double the number of behaviorists as it heads into the higher rigors of CPC+, Mills said.

The infusion of such expertise is a hit. "Primary care teams are absolutely thrilled," he said. "It's kind of the killer app of health care transformation right now." But it's more than a purely clinical benefit. "Whether it's a spiritual connection or a higher-order connection here, it really has been gratifying to see physicians respond to this and feel like they're finally able to do the good for the patient's need as opposed to just giving him prescriptions that don't get to the root of the suffering."

As Ascension presses on with the integration of behavioral and physical care, "It's great to be working in a mission-oriented environment, where we are paying attention to mind, body and spirit collectively," said Hartmann. "The fact that we're able to tackle this, but to tackle it collectively and help to reduce the stigma by normalizing our [patient care] behaviors, I think it sends a very strong message."

JOHN MORRISSEY is a freelance writer specializing in health care delivery, policy and performance measurement. He lives in Mount Prospect, Ill.

NOTE

1. World Health Organization, "Depression," Fact Sheet, February 2017. www.who.int/mediacentre/factsheets/fs369/en/.

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