Sustaining integrated **H**ealthcare **A**cross **P**rimary care **E**fforts: **SHAPE**

There is growing need to improve healthcare at the interface of general medicine and mental health, behavioral health, and substance use.[1] Better integration of the artificial separation of mental health from physical health is one way to help achieve the predominate health policy of the land, the triple aim (decrease cost, improve outcomes, and enhance the patient experience of care).[2] Since it is well established that primary care manages either directly or indirectly anywhere between 40-80% of patients with mental health, behavioral health, or substance use disorders[3,4], there is an opportunity to better address the comprehensive needs of the patient and the community through integration.

Consider that approximately 20% of patients consume 80% of available resources [5] and often these patients present with a variety of underlying mental health concerns that could be more effectively addressed through an integrated primary care model (but are often not addressed).[6] Improved detection and treatment of mental and behavioral health issues improves medical diagnoses and can assist in addressing the greater than 70% of common symptoms with frequently unknown etiology.[7]

The range of impact from adopting an integrated approach, containing mental health, behavioral health, and substance use treatment within primary care, includes improved access to and utilization of mental health services, increased patient satisfaction with medical services, improved medical provider satisfaction, improved patient compliance with treatment regimens, improved clinical outcome for patients, maintained improvement in clinical outcome, increased cost effectiveness in service delivery and actual offset of medical costs by the addition of behavioral health services.[8] Consequently, to improve the delivery of comprehensive services in primary care, the inclusion of mental/behavioral health is both indicated and essential.[9]

> By not integrating care, fragmentation prevails.

The Problem

Regardless of how effective mental health, behavioral health, and substance use integration can be in primary care, there remains a substantial barrier to financially sustaining these innovative models.[10,11]

In a 2011 survey sponsored by the Colorado Health Foundation[12], 78% of responders who have integrated care reported supporting their programs through grants. To provide integrated services

overall cost were reported to be covered 47% by grants, 21% by clinic revenues, and 32% by organizations absorbing the costs. Primary obstacles to sustaining integrated services include billing restrictions and equitable rates of reimbursement for integrated care services. Although, initial set-up costs for integrated services may appear cost prohibitive, data projections indicate substantial cost savings opportunities exist in the long run when the physical and behavioral health of these patients is improved.[13] These numbers may become more impressive when billing restrictions and billing equitability are effectively renegotiated.

Implications - The Potential for Savings

Cost Differential by Chronic Medical Condition for Patients with at least One Co-morbid Behavioral Condition

Chronic Medical Condition	Total Annual Cost Differential (in millions)
Arthritis	$132.2
Asthma	34.7
Cancer (Malignant)	67.5
Congestive Heart Failure	8.1
Chronic Pain	50.1
Chronic Kidney Disease	6.8
COPD	30.7
Diabetes	88.8
Hypertension	116.4
Ischemic Heart Disease	27.0
Osteoporosis	4.8
Ischemic Stroke	5.6
Hypercholesterolemia	83.0
Healthcare Cost Differential	**$656 million**

* For a population of 1 million lives, assuming 100% of the cost differential between patients with and without co-morbidity.

Solution

Justifications for greater integration have focused on cost-offset [14,15], such that the additional expense of providing mental/behavioral health services in primary care is offset by the subsequent reduction in associated healthcare costs.[16] Furthermore, as a result of the implementation of an integrated primary care model, cost analyses have shown decreases in absence from work [6], improved overall work productivity and performance.[17] Given the current financial climate in healthcare, integration innovations are dependent of grant funding; however, this is not a sustainable model. Financial support improvements are necessary in order for integration efforts to be effectively maintained. If adequate financial support is accomplished, then state and federal governments, insurers, grant organizations, tax payers, and individuals stand to gain abundance in fiscal healthcare savings as well as overall health gains.

However, opening up a new code is not the answer to achieve sustainability.

Working towards a new payment mechanism for integrated healthcare requires us to fundamentally rethink what services we are delivering and how a global budget can support said services. For integrated behavioral health within primary care, part of the reason many initiatives have not been financial sustainable is that the traditional fee for service mechanisms force mental health providers to do traditional mental health visits. These services, while important, are not always the best use of a behavioral health provider in primary care. To this end, the SHAPE project (more here: http://bit.ly/Pb57ve) examines what happens when we change the payment rules for behavioral health and primary care and look to offer a way to globally pay for sustaining the cost of the integration intervention. This is not just another per member per month payment (PMPM), but a true global budget that looks at the cost of integration – the program design – and creates a model within a global budget to pay for it. Actuarial modeling can study it carefully to ensure its sustainability and benefit to the practice and community. Since there is really no science to the PMPM, this approach allows for a payer (or evaluator) to look at the practices performance and allocate resources accordingly to make the biggest impact on outcomes (clinical and financial).

In determining the payment to integrated providers, the following factors are critical:

- **Cost:** The total cost of compensation to the behavioral health providers, related clinical and population interventions must be taken into account. Failure to cover the cost of personnel and services will undermine integration and/or trigger a reversion to FFS "revenue generation".

- **Panel Size:** A larger practice panel may require more integrated services and patient supports. Under resourced practices will make a smaller impact upon population health and total cost -- even if interventions are prioritized appropriately.

- **Panel Complexity:** Patients with greater needs require greater support. Payments should be 'risk adjusted' to afford the time and focus to serve patients with complex conditions and circumstances -- before, during and after patient encounters. Risk adjustment and panel stratification functions must enable the practice to systemically *predict, prioritize* and *prevent.*

- **Program Design and Alignment:** Payments should be contingent upon measured adherence to evidence and best practices, and alignment with identified needs and gaps in the entire patient panel.

In short, payments for integrated behavioral health should be made in a manner that is consistent with payments for comprehensive primary care as a whole (i.e., on a 'non-volume, non-encounter, risk adjusted' basis). Projects like SHAPE can easily be replicated throughout the country in an attempt to better test and support the integration of mental health, behavioral health, and substance use with primary care.

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