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Structural Components of Integrated Behavioral Health Care: A Comparison of National Programs

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Abstract

Initiatives that support and incentivize the integration of behavioral health and general medical care have become a focus of government strategies to achieve the triple aim. We describe the components of four large-scale national initiatives aimed at integrating care for a wide range of behavioral health needs. Commonalities across these national initiatives highlight health care and social service needs that must be addressed to improve care for people with co-occurring behavioral health and general medical conditions. These findings can inform how to design, test, select, and align strategies with the most promise for integrated care in a variety of settings.

Keywords

Integrated Care; Integration; Serious Mental Illness; Mental Health Policy; Implementation

Over the past three decades, policymakers have implemented various strategies to integrate the delivery of care for individuals with comorbid behavioral and physical health conditions. These individuals—particularly those with a serious mental illness—often have untreated medical conditions for long periods of time, which exacerbates their mental health conditions, leads to costly emergency room care and hospitalizations, and contributes to early mortality.[1]

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Integrated care is intended to work by increasing access to comprehensive, coordinated services in whatever healthcare setting a consumer finds most convenient and comfortable. Integrated care models range from positioning mental health services in primary care (primarily for the management of mild to moderate depression, anxiety, and substance use) to delivering primary care services within community mental health centers (CMHCs).[2] This paper summarizes the core components of integrated care by examining four large-scale, national initiatives: The Primary and Behavioral Health Care Integration (PBHCI) program,[3] the Certified Community Behavioral Health Clinic (CCBCH) demonstration,[4] Medicaid Health Homes (MHH),[5] and the Patient-Centered Medical Home (PCMH)[6] (see Supplementary Materials A for summary figure and in-depth descriptions of these national programs). Given that integrated care is rooted in a complex lexical landscape,[7] we used an updated version of Chung and Pincus's integrated care framework[8] to distill the key structures and processes of each initiative. This allows us to directly compare the scope of service built into each initiative.

But outside of grant and demonstration programs, there is not yet widespread uptake of integrated care. For example, less than one-quarter of CMHCs provide integrated physical health care,[9] and uptake of Medicare billing codes for collaborative care (an early integrated care model) remains low.[10] Several factors impede the adoption of the many available approaches to integrated care. These include a lack of clarity on what constitutes the core components of these models and how models and their core components can be successfully adapted to local contexts. In addition, with the exception of depression treatment in primary care, the evidence for many integration models is mixed and absent research demonstrating which structures and processes of care have the strongest evidence-base to improve outcomes.

Despite large investments in the initiatives described here, the future of integration remains uncertain. Certain settings and types of practices have implemented integrated care models differently, prioritizing different domains of integration depending on their local context and resources. This is both a strength of these national, multicomponent integrated care initiatives but also one of the challenges to their wider adoption. By describing the key elements of the four national initiatives selected for this column, we aim to shed light on future directions for implementation of integrated care.

Key Elements of National Integrated Care Initiatives

CCBHC, PBHCI, MHH, and PCMH do not represent every configuration of integrated care, but they are generally well-defined and reflect a continuum of models that utilize different financial strategies (e.g., grants, case rates, prospective payment systems, and support for enhanced fee-for-service payments) and target different populations. While some of these initiatives have been applied to youth, we focus on their application to adults. We did not review the Collaborative Care Model, which was initially studied as the IMPACT model for depression care and has been adapted for other mental disorders in primary care, because it has already been extensively reviewed in the literature.[11] The remainder of this column succinctly summarizes the key elements of these four national integrated care initiatives (see Supplementary Materials B for the full matrix comparing programs).

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Multidisciplinary teams:

All four initiatives involve reorganization, addition, or reassignment of personnel to deliver new services, such as implementation of chronic disease management protocols and wellness programs. These teams typically involve some combination of primary care providers (physician, nurse, nurse practitioner), care managers, behavioral health specialists, peer support staff, and wellness coaches. These staff may be employed by the same organization or partner organizations.

Population health management:

All four initiatives require systematic screening and monitoring for chronic conditions, and some of them have requirements to conduct comprehensive assessments of health and social needs. They also employ various health information technologies (IT) to support monitoring health status, track the delivery of routine preventive care, and facilitate information sharing across providers.

Access to routine and urgent care:

All four initiatives include strategies for expanding the hours and locations of services to improve access to care. They also require clinicians providing crisis care to promptly share clinical information with the client's regular provider.

Decision support for measurement-based, stepped care:

Decision-support is inconsistently described across programs, suggesting that research on stepped care interventions for serious mental illness, specifically within integrated care models, is an area for further development.

Self-management support:

All four initiatives require involving families, caregivers, and support persons in defining consumers' care goals, in order to place consumers at the center of the care team and ensure that they are actively engaged in creating their own care plan. These initiatives also incorporate engaging consumers in chronic disease management and wellness services to change health behaviors (for example, tobacco use and exercise). However, the specificity of the implementation requirements and expectations regarding the intensity of these services varies across initiatives.

Ongoing care management:

The target populations, staffing, clinical activities and incentive structures of care management expectations are highly variable between the four initiatives, though each does include some form of expectation for longitudinal chronic care management.

Seamless referral process:

These initiatives have varying requirements to improve referral and information sharing processes between behavioral health and general medical providers, including formal practice agreements, data sharing protocols, and integrated or linked electronic health records.

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Mechanisms to facilitate coordination of care:

The four initiatives primarily focus on health IT strategies to support referral tracking, coordination, communication and transitions between episodes and levels of care. Strategies to advance coordination include incentives aligned with monitoring quality and timeliness of response, as well as outright requirements to develop written care transition protocols with real-time information sharing.

Linkages with community and social services:

All four initiatives require primary care providers, mental health providers, or both, to maintain referral relationships with other providers who can help address social determinants of health. However, the specificity in the types of providers and formality of those relationship differs across initiatives.

Systematic quality improvement:

All four programs identify performance monitoring and quality improvement as essential to advancing integrated care.[12] They also describe advisory boards with diverse stakeholder representation and consumer participation to enhance accountability and contribute to quality improvement initiatives.

Sustainability strategies.

We found sustainability strategies included in each integration model, which are inherently related to the scope, intensity, longevity and maturity of a program. These include identifying a primary payment source and diversification of funding, prioritizing workforce development and engagement with policy change, and ensuring access to affordable care that is available to all. Program applications require that sustainability strategies be well-developed from the outset and not a reaction to time limits on grants or other program funds.

Implications for Policy and Practice

Following the examples of the four initiatives and the structure of an established framework, policymakers, payers, providers and researchers can adapt and align existing systems of care or create new approaches that, no matter the innovation, ensure a foundational set of essential services for both behavioral health and general medical care. Different practice settings will likely prioritize different elements of integrated care; for example, an initiative to create a comprehensive health home for people with serious mental illness might focus on screening for medical conditions, referrals and care coordination, whereas large primary care clinics may focus on hiring behavioral health providers as members of their primary care team. Comprehensive assessment of program quality and costs is essential for demonstrating the value of the services they provide as well as estimate cost and pricing strategies for supporting necessary infrastructure. The components described above can also help guide the selection and reporting of quality measures.

As evidenced by the initiatives described here, integrated care policies can be shaped both from the top-down and the bottom-up. Federal and state initiatives can create collaboratives and information exchanges for delivery systems and health plans to learn about how best

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to support integrated practice improvements. Local initiatives can help shape how states develop regulatory requirements and incentive payment models. Local delivery systems, specialty clinics, individual practices, and social service providers are likely to benefit from clearly articulating their entire scope and cost of integrated care to ensure that emergent policy and funding opportunities can sustain effective integrated care. This can include start-up activities (e.g., funds to renovate space to accommodate co-located services, legal fees for drafting MOUs) and engagement with key social service partners (e.g., housing, transportation). Collaborations with funders to develop new approaches to financing integrated practice (e.g., measurement-based care, value-based payments, and shared savings) that is mutually beneficial (e.g., increased accountability, with incentives for meeting quality standards) may also help sustain integrated practice.

The integrated care initiatives discussed here have broad requirements and their implementation varies across states and communities given differences in reimbursement strategies, provider capacity, and consumer characteristics. As such, no single solution to providing high-quality integrated care will work across all contexts; further research is needed to elaborate implementation best practices across settings. Nonetheless, our structured synthesis of essential components can help providers and policymakers understand and advance comprehensive models of integrated care with basic, broad building blocks and accordance with their specific needs and priorities.

Finally, these cross-cutting themes should be taken into account by behavioral health and primary care practices moving toward integration:

Workforce:

The models described here could be strengthened by including requirements that behavioral health and general medical services be provided or overseen by qualified personnel. These measures could ensure that providers are working at the top of their license to address workforce shortages while also better engaging paraprofessionals and the whole office staff in delivering integrated care to maximize touchpoints with the client.

Heath Information Technology:

Many health IT systems do not readily facilitate information exchange, decision-making support or measurement-based care either within clinics or between providers. As demonstrated during the COVID-19 global pandemic, telemedicine has great potential to improve accessibility to integrated care.[13] There is a need to determine which components of integrated care can be realistically supported by telehealth, and which populations are most likely to benefit.

Social Determinants of Health:

Future integration initiatives must do more to address equity and related social determinants of health. While cultural competence trainings were described in all programs, integration efforts should also take into consideration factors contributing to structural inequities. For example, screening for social determinants that might impede engagement in care (e.g., housing, transportation, childcare, income, food security) can help identify barriers

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to care. Furthermore, there are inconsistencies between programs regarding promoting access and engagement in services for special populations such as veterans, Indigenous persons, and people living in rural areas. Protocols for working with law enforcement might be particularly useful for diverting clients with serious mental illness and substance use disorders away from the criminal justice system and into appropriate care.[14]

This systematic comparison of the components of four prominent initiatives integrating behavioral health and general medical care demonstrates the multiple, complex considerations that must be addressed in improving health services for these high-need, high-cost populations. The framework presented herein can help assist providers, researchers, and policymakers to better design, develop, test, and align programs to incentivize and implement effective integrated care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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