Health Federation of Philadelphia: Better Client Outcomes Through Integrating Behavioral Health Care into Primary Care

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Summary

Behavioral health care is severely needed within the fabric of our healthcare system, but is rarely affordable or accessible. Up to 70 percent of patients have a behavioral health issue that is co-occurring with or complicating their physical health. However, most patients referred to mental health specialists by their primary care providers do not subsequently seek treatment. This could be a result of the social stigma against behavioral health, or it can be attributed to issues of time, geography, or money. Also, there is a shortage of behavioral health specialists within the specialty care system, so it is also an issue of capacity. These untreated behavioral health issues can lead to decreased quality of life for the patient and increased physical health problems.

In Philadelphia, the Health Federation of Philadelphia (HFP), led by Natalie Levkovich, has been working for the past several years to develop, refine, and disseminate a model of behavioral health care integrated within a primary care setting. HFP works with community health centers that serve the uninsured and the underinsured. In addition to comprehensive primary care, these health centers seek to provide behavioral health care that is accessible, is effective, and begins to address the vast need in low-income communities.

Introduction

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In Philadelphia, as well as across America, access to behavioral health care is not commonly offered in a primary care setting. This can create a number of obstacles for the patient receiving treatment.

Take Joel, for example, a 50-year-old African-American man. He arrived at a community health center in 2009. He did not know what he needed to be treated for, but said that he "just didn't feel right." Joel has had several chronic medical issues, and throughout this visit it became clear that he also had issues with memory loss and anxiety. He was afraid of having any lab work done and did not want to see any specialists.

Had Joel arrived at the health center a few years ago, no

systems would have been in place to respond to and treat his behavioral health issue. Said his primary care provider (PCP), Joel "would have been presented to me and I would have referred him to neuro again and again." Even if a referral had been made, given Joel's anxiety and fear of specialists, the likelihood that he would follow up on mental health services is extremely low.

However, because of HFP and its innovative work to integrate behavioral health services into a primary care setting, Joel's issues did not have to go untreated. HFP's integrated approach has been instituted within several Federally Qualified Health Centers (FQHCs) in the Philadelphia area with the aid of Community Behavioral Health, a managed behavioral healthcare organization, and the Philadelphia Department of Behavioral Health. The model fully integrates behavioral health professionals (such as psychologists, therapists, and social workers) into patient flow in busy primary care practices.

The behavioral health provider sees the patient for a highly focused assessment and intervention. Treatment is focused on negotiating behavior change and teaching symptom management to improve that individual's functional status. The behavioral health specialist acts as a consultant to PCPs regarding treatment planning. In addition, any medication deemed necessary can be prescribed by the PCP on site. This model does not replace traditional therapy and is not appropriate for all individuals, but provides an option for those who would

not otherwise have access to behavioral health care because of limited availability, stigma, cost, or other barriers.

This was the case for Joel, who happened to be visiting a community health center with the integrated model in place. When the PCP took note of the patient's distress and anxiety, he called in a behavioral health specialist. The specialist provided teaching around relaxation techniques to help Joel get the lab work he needed, including a lumbar puncture, despite his fear. The specialist also worked with Joel to develop a chronic care calendar to help him organize his healthcare needs and ward against memory loss of appointments. Without the behavioral health specialist, Joel would not have received the care he needed (HFP 2009b).

The integrated model has dramatically increased access to behavioral health care for medically underserved populations by removing previous barriers such as social stigma, lack of time and money, and shortage of behavioral health specialists. In 2009, over 3,600 patients were seen under the integrated model. Conservative estimates suggest that this model saved the Philadelphia healthcare system more than $3 million that year. This represents a staggering social return on investment, facilitated by the HFP and Levkovich. HFP has successfully implemented, coordinated, and sustained this model, which some are calling the first instance of "primary behavioral health care."

The Problem: Inadequate Behavioral Healthcare Services for Poor

Community health centers have been providing primary care to medically underserved neighborhoods for decades. Annually, more than 260,000 patients visit such centers in Philadelphia. Because of poverty or lack of insurance, many of these patients would otherwise not have access to care. Traditionally, these health clinics provide primary care and refer patients requiring behavioral health care to specialists at offsite locations.

Some experts estimate that up to 70 percent of patients have a behavioral health issue that is co-occurring with or complicating their physical health. However, most patients referred to behavioral health specialists do not subsequently seek treatment. Untreated mental health issues can lead to decreased quality of life for the patient and increased physical health problems, as well as an increased cost to the healthcare system.

However, the primary care setting is now widely recognized as the initial, and often only, opportunity for people to access behavioral health services. PCPs provide the majority of mental health care in the United States. Among one in five adults will experience a diagnosable mental health condition in any given year (U.S.

Department of Health and Human Services 1999). And more than 40 percent initially seek help in primary care settings (Chapa 2004). But behavioral health services are not typically offered within the primary care setting, in either community clinics or family practices. Access to behavioral health treatment is an issue that crosses all income levels.

To add to the problem, there is a national shortage of accessible behavioral health specialists. In a recent survey of PCPs, about two-thirds reported that they could not get outpatient mental health services for patients — a rate that was at least twice as high as that for other services (Cunningham 2009).

The issue of access is heightened for low-income communities. FQHCs have been providing primary care to medically underserved neighborhoods for decades. In Philadelphia alone, thousands of people visit these community health centers. As a result of the complications and trauma of living below the poverty line in stressed communities, many low-income individuals suffer from higher rates of behavioral health issues. Left untreated, these issues can lead to an increase in other health problems and use of other health services. Studies have shown that patients suffering from mild to severe depression are two to three times as likely to seek care for physical health problems (HFP 2009a).

The Process: How HFP Got Involved

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Five years ago, HFP was approached by Community Behavioral Health, a managed behavioral healthcare organization, and the Philadelphia Department of Behavioral Health. They were asked if member community health centers could begin to provide behavioral health services, as the existing behavioral health system could not meet the demand.

Why did the city approach HFP to help solve this issue? For over 25 years, HFP, a registered 501(c)(3), has served as a network for community health centers in Southeastern Pennsylvania. They provide a forum for the region's FQHCs and the Philadelphia Department of Public Health to collaborate and mobilize resources for their shared goal of improving the quality of health care in the region. HFP is in a unique position to address emerging healthcare issues by bringing together member health centers, outside experts, and funders. To address the behavioral healthcare issue, HFP and the city conducted a series of dialogues and work groups. Their chief aim was to simplify the administrative requirements and develop a clinical model that would allow primary care practices to provide behavioral health services.

HFP is headed up by Natalie Levkovich, and much of the model's success has been attributed to her leadership. Dr. Neftali Serrano, a primary care psychologist who has helped provide training for the integration model, says,

"People usually have either an excellent grasp of what is going on clinically or an understanding of what needs to happen behind that with funding and policy." Levkovich, he argues, has both. "She combines expertise in a variety of areas. She has knowledge of the health system and strong relationships with folks in the nonprofit and state level. But she doesn't just have that big picture; she also understands the model and what it is supposed to look like on the ground."

The Solution: An Integrated Model

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To improve the ability of community health centers to provide behavioral health services, HFP addressed the issue of access from both a systematic and cultural perspective, looking at issues of capacity and the stigma attached to receiving treatment. The behavioral health integrated model brings the work of the behavioral health specialist into the primary care setting of health centers by making specialists a part of the primary care team and allowing them to see more patients with shorter, more problem-focused visits. The behavioral health integrated model "fits" with the way that primary care is practiced — it is fast-paced, population-based care that is both preventive and therapeutic. Behavioral health specialists document their care in the medical record, alongside the primary care notes, using a notation format familiar to

PCPs.

When the PCP notices a behavioral health issue affecting a patient during the course of an examination, the provider calls in the team's behavioral health specialist for a consultation. The specialist can provide the following services (HFP 2009b):

- Assessment and diagnosis
- Psychoeducation for the patient and the patient's support network
- Development of a short-term behavioral plan
- Referrals or suggested prescriptions as necessary
- Patient education
- Behavioral activation
- Relaxation/stress reduction
- General coping strategies
- Pain management
- Supportive listening
- Cognitive techniques
- Problem solving/Goal setting
- Consultation to the PCP regarding the diagnosis, the recommended treatment and follow-up and, in some cases, the medication

This model increases system capacity by allowing behavioral health specialists to see up to 12 patients a day versus the traditional four to five patients. The cultural stigma and physical challenges of seeking behavioral health treatment are lessened because a separate visit is

not required. In the second year of the model, over 2,000 patients received behavioral health care as part of their primary care visit. By 2009, that number had jumped to more than 3,600 patients (HFP 2009b).

In its role as the model champion, HFP has played an instrumental part in ensuring the success of the behavioral health integrated model. HFP and Levkovich were able to mobilize resources among the key players, provide training to new participants, and create a community to share lessons learned. Dr. Serrano has observed that "what has held this [model] together is the Health Federation continuing to advocate for policy and training and the clinicians to do the work," and says the success of the program is rooted in "the ability of the Health Federation to make this a priority for the clinics and the clinicians." Successful implementation of the integrated model was also due to the essential leadership and contribution of the behavioral health specialists and the commitment and vision of their executive leaders. Dr. Serrano also attributes the success of the model to the behavioral health specialist and PCP staff on the ground; they were "willing to be flexible and trainable and take the model to heart."

Implementing the integrated model within the existing healthcare system was extremely difficult because so many elements of the status quo needed to be addressed. The key in the early stages of the program was to implement a successful pilot without disrupting the usual

operations of health centers, thereby demonstrating the effectiveness of the model and serving as an example to other health clinics. HFP started by focusing on two main areas: altering the behavior of the behavioral health specialist and the PCP through skill building, and streamlining the reimbursement process of behavioral health treatment with Community Behavioral Health (the HMO) to encourage adoption.

To encourage behavioral health specialists and PCPs to accept the integrated model, HFP brought in nationally known integrated care experts, including Dr. Kirk Strosahl, to introduce the concept and initiate dialogue between PCPs and behavioral health specialists. PCPs are not used to having these specialists on-site and do not automatically think to call in the specialist for a consultation. Behavioral health specialists are used to sessions with patients that involve a prolonged diagnostic and therapeutic period, and they needed to learn new skills and methods to implement the "brief, problem focused consultation model" (HFP 2009b).

After convincing the providers to give the model a try, HFP provided more detailed training to providers at the pilot site, Delaware Valley Community Health, and sought to identify "early adopters" of the model to implement it. Early adopters included 11th Street Health Center, a partnership between Family Practice and Counseling Network and Drexel University, and Esperanza Health Center, a faith-based community health center.

Experiencing firsthand the success of an integrated model was crucial to converting the providers. The behavioral health specialist realized that the consultations were still extremely meaningful to the patient and often more effective than the traditional referral model. One specialist stated that “it is so gratifying to work in a way that our patients really respond to.” At the same time, the PCP realized that having a behavioral health specialist did not disrupt normal operations and helped the patient to recover faster; says one PCP of the model: “In the past we didn’t want to go there [assessing behavioral health issues] because it would open a can of worms. Now I can’t imagine working without a behavioral health consultant.”

On the administrative front, HFP worked closely with Community Behavioral Health to change and streamline the reimbursement policies. In the Medicaid managed care environment of Southeastern Pennsylvania, the PCP is reimbursed through a physical health HMO and the behavioral health specialist through a behavioral health HMO. In order to qualify for reimbursement, behavioral health treatment had to include a long and exhaustive assessment. Through an iterative process, HFP and Community Behavioral Health were able to arrive at a documentation standard that fits the model, meets Community Behavioral Health’s standards of clinical accountability, and qualifies for reimbursement. Community Behavioral Health developed credentialing

standards, and identified a billing code and a billing rate to apply to the integrated behavioral health consultation model. "It's really unique to engage an insurer in that way," says Dr. Serrano. "That is to the credit of Community Behavioral Health and to what Natalie and the Health Federation have been able to do."

Today, the primary care visit is still covered by a Medicaid HMO, and the behavioral healthcare portion is now covered by Community Behavioral Health. This was a huge systems change instigated by HF and brought about through dialogue and collaboration. Also, in accordance with policies for Medicaid reimbursement of FQHC services, both the primary care and the behavioral health visits are eligible for additional cost-based reimbursement directly from the State Medicaid program. HF was able to advocate successfully that both visits occurring on the same day are eligible for payment.

HFP continues to provide considerable support for the implementation of the behavioral health integrated model, through training, community building, and advocacy. Ongoing training for the providers and sites that are implementing the model includes access to external experts such as Dr. Serrano as well as internal expertise that HFP has developed through its implementation experience. HFP also hosts monthly meetings where practitioners of the model can gather to continue their professional development, share lessons learned, ask questions, and provide encouragement.

Key Components for Systemic Change

Through its experience in implementing the behavioral healthcare integrated model, HFP has identified five key components for systemic change:

- **Organize a collective voice and pooled learning:** The scale of the program was one of its success factors; the resources needed to create the change were too extensive for any single clinic or organization to take on alone, such as working with insurers to change the reimbursement structure. Having a centralized way of organizing a network of sites and providers made the investment to implement the integrated model more feasible.
- **Cultivate champions:** Each stakeholder has daily operations that consume most of its resources. Without a champion, development of this model would not have taken consistent priority. Provider champions or "early adopters" are also needed on the ground to promote and demonstrate the implementation of the model.
- **Create a sense of community:** A community eases some of the challenges in implementing the model by providing support to those stakeholders who are breaking away from the status quo, sharing lessons learned to make the process smoother for the next person, and creating accountability for participants to

stay invested in the program.

- **Start where they are:** The behavioral healthcare integrated model is so successful because it worked within the existing system to identify what could and could not be changed and at what pace. It did not seek to fit the existing system into a preconceived model.
- **Organize a multi-pronged strategy:** Many changes needed to come together at the same time in order for the behavioral healthcare integrated model to work (i.e., skills, structure, policies). Approaching the problem from several angles also creates a critical mass to speed up acceptance of the solution (HFP 2009: 17).

Results and Social Return on Investment: $3.6 Million

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The results of the model have been strong. Patients who are offered behavioral health care are happy to know that the service is available. Some report that they are coping just fine and don't need the service; however, many have something that they want to discuss and are very grateful that someone is there to provide immediate support for their concerns.

The types of behavioral healthcare treatment provided

vary greatly depending on the patient. Because the behavioral health consultation approach is a generalist model, the behavioral health specialists are able to address a wide range of patient concerns. Consistently, however, patients are able to take the treatment plan developed during the behavioral health consultation and start using it right away. One patient who received behavioral healthcare treatment said, “It’s hard, but I am trying. I did speak with my sisters and my boyfriend about my problems, and I feel less alone. I am using the list you gave me of things I can do each day to help myself. Thank you for taking the time to listen and help.”

In a 2009 study of healthcare expenditures, the Agency for Healthcare Research and Quality found that mental disorders and trauma-related disorders were two of the top five most costly conditions. These two conditions also represented the largest increase in expenditures from 1996 to 2006. The money spent on mental disorders alone rose from $35.2 billion in 1996 to $57.5 billion in 2006 (Soni 2009). Mental health care is currently costing the healthcare system a staggering amount — but how much more does it cost when mental health issues go untreated?

The few studies that have examined the direct and indirect costs of integrated behavioral health care from a societal perspective have found that collaborative (integrated) care was associated with overall cost savings (Katon 2008). These findings are further substantiated by

emerging evidence showing that unemployment is reduced and economic productivity increased as a consequence of case management approaches for depression (Rost, Smith, and Dickinson 2004; Schoenbaum et al. 2001).

It should be noted that costs initially increase because the model itself increases the likelihood that a patient's behavioral health issue will be identified and addressed. As stated previously, more than 3,600 behavioral health patients were served by HFP's model in 2008. HFP reports that it spent $61,892 (a portion of a multi-year grant from the Aetna Foundation) during that year to train clinicians and coordinate the successful implementation and development. A very conservative estimation is that HFP's model has saved the system approximately **$3.7 million**.

The following formula was used to calculate the social return on investment of HFP's behavioral health integration model (CHC = community health center). The formula takes a number of cost savings generated by the integrated model and adds them together to calculate the total amount saved by this innovation.

When developing this formula, a number of assumptions were made. First, it is assumed that a percentage of patients with untreated behavioral health issues will ultimately seek emergency care. A conservative estimate of 5 to 15 percent of the 3,600 patients was used. It is

also documented that a patient with an untreated behavioral health issue is more likely to use additional health services, so the estimated cost of additional health center visits is factored into the equation. It is also assumed that a small percentage of patients may miss work as a result of a decrease in functionality and an increase in physical health ailments brought on by behavioral health issues.

Visiting the ER vs. a CHC		Patient Return Visits		Specialist's Productivity		Patient Functionality
(3,600 patients x .05) x 72 hrs. x $277/hr	+	(3,600 x .05) x $150 x 3 visits	+	(720 days - 300 days) x $300 / day	+	(3,600 x .1) x $58 / day x 3 days

= $3,694,104.00

When taking into account that a significantly greater number of patients may use the emergency room because of untreated behavioral health issues (15 percent of all patients as opposed to 5 percent), this figure skyrockets to **$11.7 million**. It should be stressed that this equation is based on extrapolation and estimates of the following:

- The cost of 5 to 15 percent of 3,600 patients visiting the emergency room for their untreated behavioral health condition
- The cost of patients returning to the community health center for subsequent primary care visits as a result of their untreated behavioral health condition

- The cost savings of a behavioral health specialist being able to see up to 12 patients during the workday, as opposed to four
- The cost of 10 percent of patients missing work as a result of decreased functionality brought on by a mental health issue

In 2008, there were nine behavioral health specialists trained and working in HFP member health centers with the integrated model. Based on HFP's budget of $61,892 for the model during that year, it costs approximately $6,877 to train each specialist. This does not include cost of the clinical staff itself, which the clinic absorbs. On average, an on-site behavioral health specialist is paid $78,000 per annum (including benefits). The budget of $61,892 does not include the actual cost of behavioral health consultations, which average a reimbursable cost of $150.
The impact of the model can also be measured in patient satisfaction. During 2007, more than 2,000 people received behavioral health services in participating health centers. The organization launched a small pilot patient satisfaction survey. When asked how much they were helped by the service, the patients rated it 3.56 (on a scale of 1 to 4). When asked if they would recommend the service to friends and family, patients gave the service a 4.0 rating. For more survey results see the appendix.

Looking Ahead

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Since its inception three years ago, the behavioral healthcare integrated model has dramatically increased the access and efficiency of behavioral health care to community health center patients. Currently, six health center sites and nine behavioral health professionals are serving patients with an integrated approach to primary care and behavioral health (HFP 2009a).

Going forward, HFP and its partners are still looking to address some challenges:

- **Quantifying results and establishing a quality improvement program**: It is clear that the behavioral healthcare integrated model has improved the behavioral healthcare system by increasing efficiency and effectiveness. The next step is to quantify the advantages and measure the model's progress. In the examination of social return on investment, we have attempted to pinpoint several areas where the model has made an impact.
- **Scaling up the program to pediatric patients and additional health centers in Philadelphia:** The behavioral healthcare integrated model works well in the Philadelphia area because of several possibly unique factors. It was developed with a high degree of involvement among all participants, and it has a unifying organization, HFP, to spearhead its progress. Expanding the model will require ongoing resources

to support training and dissemination as well an available supply of qualified behavioral health specialists.
- **Obtaining continued funding:** Although we have shown in the social return on investment that the model yields significant cost savings, its implementation actually increases the cost to the health centers. Depending on the proportion of Medicaid insured patients, reimbursements can offset a significant portion of the labor costs. Also, in order to continue developing and replicating the model, more training and education, as well as ongoing coordination and advocacy, are needed.

While HFP works to address these challenges, it will continue to support the implementation of the behavioral health care integrated model in Philadelphia so that patients will receive the care they need.

A Success Story

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Mrs. Jones is a 33-year-old woman who is in the office to see her PCP following a recent visit to the ER with complaints of chest pain, shortness of breath, and heart palpitations. The patient was told that she was experiencing a panic attack. She has a history of addiction and does not want to take medications for panic. The patient is seen by the behavioral health specialist, who

educates her about anxiety and helps her to look at her symptoms differently. She is taught diaphragmatic breathing and sensory stimulation practices to help distract her during a panic attack. The motivation for using these techniques is developed by working with Mrs. Jones to identify things she values and looking with her at the ways in which her current strategies are moving her closer to or further from these goals. Again, self-care goals are developed and she is followed by the PCP and behavioral health specialist to see if she is improving or needs more assistance. If she does, she will be referred for therapy. But if her anxiety is improving with these techniques, she is encouraged to continue using them, and the mental health system has one less person on the waiting list.

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Appendix

Appendix

In 2008, HFP launched a small pilot patient survey. The following is a summary of some of the findings.

- How much were you helped by this service? 3.56 rating on a 1–4 scale
- How much were you involved in the decision about your treatment plan? 3.6 rating on a 1–4 scale

- Did you get what you needed? 3.75 rating on a 1–4 scale
- Would you recommend this service to friends and family? 4.0 rating on a 1–4 scale

Additional findings from a chart audit (103 charts reviewed) with key findings regarding the profile of patients reached:

- 95 percent minority
- 59 percent with chronic disease
- 47 percent with depression
- 32 percent with adjustment disorder
- 27 percent with history of trauma (e.g., abuse, significant loss)
- 51 percent showed improvement of their presenting complaint