

OLDER AMERICANS BEHAVIORAL HEALTH

Issue Brief 8: Integration of Behavioral Health and Physical Health Care



Rationale for Integrated Physical and Behavioral Health

Behavioral health problems—such as alcohol or medication misuse or abuse, depression, and anxiety—are prevalent in older adults, and each affects up to 15% of older adults.¹ These problems have a substantial impact on older adults. They are associated with decreased quality of life, functioning, and treatment adherence; poor physical health; and overuse of medical services. Despite the impact of these problems, they are often undiagnosed and undertreated.

Older adults that access behavioral health care often do so through their primary care providers, and treatment has largely consisted of prescription medications.² Yet, many providers are poorly equipped to address behavioral health issues due to patient issues (e.g., co-occurring medical conditions), provider issues (e.g., lack of knowledge and time to screen for behavioral health conditions and deliver non-pharmacological interventions), and system issues (e.g., insufficient time to screen, diagnose, and treat both physical and behavioral health problems).³

Integrated care models have been developed to overcome these issues. While some models embed physical health services into behavioral health settings, this issue brief focuses on models that embed behavioral health services into primary care settings.⁴⁻⁶ In these models, older adults receive screening and treatment for behavioral health problems in the primary care setting, and receive care from both their primary care provider and a behavioral health specialist that is embedded within the primary care team.

Integrated care models can improve treatment engagement and outcomes for older adults, when compared to more traditional methods for delivering behavioral health services.⁷⁻⁹ These models may also improve communication and coordination between primary care and behavioral health specialists, and decrease stigma associated with accessing behavioral health services.¹⁰⁻¹¹

Introduction and Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Community Living's (ACL) Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA and AoA are providing archived Issue Briefs and Webinars, particularly in the areas of alcohol and prescription drug use and misuse, suicide, anxiety, and depression among older adults, and are partnering to get these resources into the hands of aging and behavioral health professionals.

This Issue Brief is intended to help primary and behavioral health care providers develop strategies to integrate care for older adults. It provides:

- **Information** on the rationale for implementing integrated primary and behavioral health care models;
- **Examples** of integrated care models that target older adults; and
- **Recommendations** and **Resources** to help aging services, behavioral health, and primary care providers implement integrated care programs.

Integrated Care Programs

Effective integrated care teams develop a comprehensive plan to address physical and behavioral health care needs, and share patient care information. The behavioral health provider can support medication management prescribed by the primary care provider and can deliver brief evidence-based behavioral health interventions, such as problem-solving therapy, interpersonal therapy, or brief alcohol interventions. The effectiveness of treatment is measured and tracked, and treatment is changed or intensified if a patient does not show improved clinical outcomes.

Integrated care models have been widely tested and implemented in the United States. The following examples illustrate core principles of well-established programs that embed behavioral health into primary care. Integrated care teams may also function effectively in other settings where older adults receive care, including inpatient care, long-term care, and social or aging services.

IMPROVING MOOD, PROMOTING ACCESS TO COLLABORATIVE TREATMENT (IMPACT)

IMPACT is a model of care designed to identify and address depression in older primary care patients. In IMPACT, a depression care manager is embedded within the primary care team and provides and coordinates depression care; educates patients about depression and its treatment; provides behavioral activation; uses the PHQ-9 depression screen to monitor depressive symptoms and response to medication, psychotherapy, or both; works closely with the primary care provider and a consulting psychiatrist to revise the treatment plan when patients are not improving; and offers a brief course of problem-solving therapy. The IMPACT Implementation Center provides a range of materials, training, and technical assistance to help organizations implement and adapt IMPACT. <http://impact-uw.org/>

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is a model of care designed to identify and address unhealthy substance use, including alcohol, tobacco, and medication misuse or abuse. Patients receive brief screening to identify unhealthy substance use or misuse. Those with

a positive screen receive a brief motivational intervention focused on changing unhealthy behaviors, or referral for additional treatment if needed. SBIRT can be delivered by a range of providers, including physicians, nurses, psychologists, social workers and pharmacists. SBIRT programs are typically located in medical settings such as primary care and emergency departments, but can also be delivered in community mental health centers or aging services settings. Additional information is available at: <http://www.samhsa.gov/prevention/sbirt/> and <http://www.oasas.ny.gov/AdMed/sbirt/index.cfm>.

SAMHSA SUPPORTED PROGRAMS

SAMHSA has recently supported a variety of programs that integrate older adult behavioral health into primary care. For example, **Bridging Resources of an Inter-disciplinary Geriatric Health Team via Electronic Networking (BRIGHTEN)**—implemented by Rush University Medical Center in Chicago, Illinois—screens, assesses, and provides treatment for depression, anxiety, and substance misuse/abuse in older primary care patients. It uses an interdisciplinary virtual team that operates via e-mail, secure website, and telephone conferencing to discuss and address needs of older adults.¹² <http://brighten.rush.edu>. Similarly, **Senior Reach**—implemented by the Jefferson Center for Mental Health, Seniors' Resource Center, and Mental Health Partners in Arvada, Colorado—adopts principles of both IMPACT and SBIRT by embedding screening, assessment, and treatment for depression and substance abuse in five primary care clinics. <http://www.seniorreach.org>. The **Brief Intervention and Treatment for Elders (BRITE)** program—implemented throughout Florida—modified the SBIRT model specifically for use with older adults with substance misuse/abuse. The goal of the Florida BRITE program is to provide substance abuse prevention services for older adults through early identification of alcohol or medication misuse/abuse and brief interventions to change behaviors. Older adults identified with more serious substance abuse problems are actively referred to treatment. In addition to primary care settings, BRITE providers screen and provide brief interventions in aging services settings, retirement communities, senior centers, and other locations. <http://brite.fmhi.usf.edu>.



KEY ACTIONS

Lessons Learned from Implementation


Aging services, behavioral health, and primary care providers and administrators can take important steps to implement integrated behavioral and physical health care programs. General recommendations across all settings include:

- Deliver care in a culturally competent manner that encompasses older adult preferences and values in health care decision-making.
- Be active and visible in your community and statewide, and advocate for effective behavioral health services for older adults.




KEY ACTIONS FOR AGING SERVICE PROVIDERS

- Develop or build upon existing integrated care models and enhance referral relationships and partnerships with these programs.
- If integrated care models are not available in your community, advocate for their development.
- Train aging service providers to screen, provide, and/or refer to services those older adults who are at-risk for depression, anxiety, suicide, or substance misuse or abuse.



KEY ACTIONS FOR BEHAVIORAL HEALTH PROVIDERS

- Identify a “champion” in the primary care setting who can advocate for the program, address emergent questions, and be involved in program design and implementation.
- Educate and assist medical providers in implementing systematic screening and follow-up for depression, anxiety, and/or substance misuse or abuse.
- Increase the effectiveness of behavioral health services by implementing evidence-based practices (e.g., problem-solving therapy, cognitive behavioral therapy, brief alcohol interventions), tracking outcomes, and taking steps to improve treatment adherence.
- Provide clear communication with primary care providers regarding the older adult’s progress with behavioral health services and information on ongoing monitoring of behavioral health symptoms (i.e., using standard assessment instruments).



KEY ACTIONS FOR PRIMARY HEALTHCARE PROVIDERS

- Incorporate brief behavioral health screening as part of the standard flow of work, such as patient paperwork or the nurse’s assessment of vital signs (e.g., Patient Health Questionnaire (PHQ-9): <http://www.phqscreeners.com>; Alcohol Use Disorder Identification Test (AUDIT): http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf).
- Use a “warm handoff” to introduce the patient to the behavioral health specialist (e.g., an in-person introduction).
- Adapt existing collaborative depression care models to include management of late-life anxiety; prevention of substance misuse/abuse; and linkages between aging service, behavioral health, and primary care networks.
- Set aside time for regular clinical case discussions between behavioral health and primary care providers, including time to discuss opportunities for improving collaboration.



KEY ACTIONS FOR COORDINATION AND INTEGRATION OF SERVICES

- Establish an automated system for initiating referrals based on triggers (e.g., depression, anxiety, or substance misuse/abuse screening instruments).
- Use standardized depression, anxiety, and substance use scales as screening tools and as outcome measures to evaluate the effectiveness of individual care and overall program implementation.
- Use data to demonstrate success and outcomes.
- Conduct regular meetings with leadership and front-line care providers to identify successes and barriers, address staff concerns, provide training, and develop plans to continuously improve the program.
- Create an effective system for exchanging information between primary and behavioral health care providers, including sharing information within the patients’ electronic health records. Identify documentation needed for each agency and develop a plan to work within HIPPA requirements.



Key Actions for Financing Services

Recent data have shown that collaborative care models result in better patient outcomes than traditional models of care.¹³ These models can also be delivered at the same cost as traditional models of care,¹³ and can be associated with lower total health care costs among older adults.¹⁴

Given improved quality of care and decreased costs, integration of behavioral and physical health fits well within models of health reform promoted within the Affordable Care Act, including: Patient-Centered Medical Homes, Accountable Care Organizations, and the Medicaid Health Home initiative.^{15,16.}

- Financing integrated care should consider quality and financial gains. Quality gains may include a decrease in the amount of time older adults spend with their primary care provider, greater engagement in care, greater patient retention, improved relationships with community partners, and a decrease in no show rates.
- Billing and reimbursement for care management services can be complex. In nearly all cases, at least some services are reimbursable. Organizations can discuss incentives for providing behavioral health care with their larger payors.
- The Center for Medicare and Medicaid Services (CMS) covers annual alcohol screening and, for those that screen positive, up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries. Counseling must be provided by qualified primary care physicians or other primary care practitioners in a primary care setting. <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249>
- CMS covers annual screening for depression for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment and follow-up. <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251>



CASE STUDY: A STRATEGY TO FINANCE INTEGRATED CARE

Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND)



changes the structure of behavioral health care delivery and financing in Minnesota.¹⁷ DIAMOND uses a “bundled payment” approach to finance the delivery of integrated behavioral and physical health care (following the IMPACT model). The payment model was developed by a collection of Minnesota medical groups, six major Minnesota health plans, the Minnesota Department of Human Services, employer groups, and patients.

DIAMOND overcomes many of the financing challenges that integrated care models typically face by using a bundled payment mechanism (with a single billing code useable only by certified DIAMOND sites) to reimburse evidence-based depression care management activities, as well as care manager and consulting psychiatrist costs. https://www.icsi.org/health_initiatives/diamond_for_depression/

Resources



- Administration on Aging: Behavioral Health webpage. See SAMHSA/AoA Issue Briefs Series. http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspx
- Health Homes and Primary and Behavioral Health Care Integration. <http://www.samhsa.gov/healthreform/healthHomes/index.aspx>
- American Psychological Association (APA). Integrated Health Care for an Aging Population. <http://www.apa.org/pi/aging/programs/integrated/index.aspx>
- National Registry of Evidence-based Programs and Practices. <http://www.nrepp.samhsa.gov>
- Center for Mental Health Services. (2011). *Treatment of depression in older adults evidence-based practices (EBP) KIT*. HHS Publication No. SMA-11-4631. Rockville, MD: SAMHSA. <http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD>
- Center for Substance Abuse Treatment. (1999). *Treatment Improvement Protocols (TIP) 34: Brief Interventions and Brief Therapies for Substance Abuse*. HHS Publication No. SMA12-3952. Rockville, MD: SAMHSA. <http://store.samhsa.gov/product/TIP-34-Brief-Interventions-and-Brief-Therapies-for-Substance-Abuse/SMA12-3952>

WORKS CITED

- ¹ SAMHSA/AoA (2012/2013). Issue Briefs Series: *Alcohol Misuse and Abuse Prevention, Prescription Medication Misuse and Abuse Among Older Adults, Preventing Suicide in Older Adults, and Depression and Anxiety: Screening and Intervention*. Accessed Feb. 28, 2013. http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspx
- ² Klap R, Unroe KT, Unützer J. (2003). Caring for mental illness in the United States: a focus on older adults. *Am J Geriatr Psychiatry*; 11(5):517-24.
- ³ Thielke S, Vannoy S, Unützer J. (2007). Integrating mental health and primary care. *Prim Care*; 34(3):571-92, vii.
- ⁴ Collins C, Hewson DL, et al. (2010). *Evolving Models of Behavioral Health Integration in Primary Care*. Milbank Memorial Fund. <http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>
- ⁵ Integrating Behavioral Health into Primary Care. *SAMHSA-HRSA Center for Integrated Health Solutions*. Accessed February 27, 2013. <http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care>
- ⁶ Parks J, Pollack D, Bartels S. (2005). *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*. National Association of State Mental Health Program Directors. <http://www.nasmhpd.org/docs/publications/MDCdocs/Final%20Technical%20Report%20on%20Primary%20Care%20-%20Behavioral%20Health%20Integration.final.pdf>
- ⁷ Bartels SJ, Coakley E, et al. (2004). Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *Am J Psychiatry*; 161(8):1455-62.
- ⁸ Bruce ML, Ten Have TR, et al. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: A randomized controlled trial. *JAMA*; 291(9):1081-91.
- ⁹ Unützer J, Katon W, et al. (2002). Collaborative care management of late-life depression in the primary care setting. A randomized controlled trial. *JAMA*; 288(22):2836-45.
- ¹⁰ American Psychological Association (APA). (2008) *Blueprint for Change: Achieving Integrative Health Care for an Aging Population*. <http://www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf>
- ¹¹ Gallo JJ, Zubritsky C, et al. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: results from a multisite effectiveness trial (PRISM-e). *Ann Fam Med*; 2(4):305-09.
- ¹² Emery EE, Lapidus S, et al. (2012). The BRIGHTEN Program: Implementation and evaluation of a program to Bridge Resources of an Interdisciplinary Geriatric Health Team via Electronic Networking. *Gerontologist*; 52(6):857-65.
- ¹³ Woltmann E, Grogan-Kaylor A, et al. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry*; 169(8):790-804.
- ¹⁴ Unützer J, Katon WJ, et al. (2008). Long-term cost effects of collaborative care for late-life depression. *Am J Managed Care*; 14(2):95-100.
- ¹⁵ Bao Y, Casalino LP, Pincus HP. (2012). Behavioral health and health care reform models: Patient-Centered Medical Home, Health Home, and Accountable Care Organization. *J Behav Health Serv Res*; 40(1):121-32.
- ¹⁶ Unützer J, Chan YF, et al. (2012). Quality improvement with pay-for-performance incentives in integrated behavioral health care. *Am J Public Health*; 102(6):e41-e45.
- ¹⁷ APA Gold Award. (2010). A new direction in depression treatment in Minnesota: DIAMOND program, Institute for Clinical Systems Improvement, Bloomington, Minnesota. *Psychiatr Serv*; 61(10):1042-44.



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