COMMENTARY

When Frontline Practice Innovations Are Ahead of the Health Policy Community: The Example of Behavioral Health and Primary Care Integration

Benjamin F. Miller, PsyD

Innovation in health care delivery often far outpaces the speed at which health policy changes to accommodate this innovation. Integrating behavioral health and primary care is a promising approach to defragment health care and help health care achieve the triple aim of decreasing costs, improving outcomes, and enhancing patients' experiences. However, the problem remains that health policy does not frequently support the integration of care. This commentary describes some of the reasons policy falters as well as potential opportunities to begin to influence health policy to better support practices that take an integrated approach to health care. (J Am Board Fam Med 2015;28:S98–S101.)

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The U.S. health-care system is actively working toward ending the separation of mental health care and medical care. In fact, we now see a proliferation of approaches to care that bring mental health and substance use services, hereafter referred to as behavioral health, into primary care.[1,2] Integrating behavioral health with primary care is not a temporary trend or just a possibility; rather, integration has become a movement.

The movement is spreading in part because of robust scientific evidence combined with stories of successful implementation.[3–6] In that regard, the studies and stories contained in this special issue are not unique. In fact, communities have been innovating their own solutions to integration for decades. When we observe practices within our communities, we often see aspects of their implementation that should be replicated elsewhere.[7] Where this special issue is unique is how it empirically describes the implementation of various integration efforts derived through rigorous observation and study, thus making it possible to begin to tease out and better understand the different elements that shape and influence what integration looks like in different settings.

Practices such as those found in this special issue have shown that in the face of profound barriers, they can successfully integrate care and build their own case for why we integrate.[8,9] These practices further the cause. They work to change the historically fragmented lens in which we view health. But they still need help. Practices need health policy change to continue their transformation so that the millions of people with behavioral health problems can get proper care. The problem is that innovation on the ground is far outpacing changes in health policy limiting scalability and adoption.

Policy is movement in a specific direction for a reason. Policy development and implementation is an essential element for helping achieve broad scale and sustainable transformation of community-based practices. And policy occurs at multiple levels. From a local, state, and national level, policy requires us to think about change systemically and thoroughly.

From the Eugene S. Farley Health Policy Center, Department of Family Medicine, University of Colorado School of Medicine, Aurora.

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Corresponding author: Benjamin F. Miller, PsyD, Eugene S. Farley, Jr. Health Policy Center, University of Colorado Denver School of Medicine, Department of Family Medicine, Academic Office 1, Mail Stop F496, 12631 East 17th Avenue, Aurora, CO 80045 (E-mail: benjamin.miller@ucdenver.edu)

Why Policy Falters

In health care, advocacy often shapes the direction and movement of a given policy. Specific groups may advocate for 1 policy while separate and unrelated groups advocate for another policy. Both entities want movement, but often in 2 different directions. Sometimes the active implementation of a policy helps 1 group while unintentionally or in some case, intentionally, not helping another group. In health care, this is frequently seen as the system itself has grown and become a cacophony of competing interests, with countless groups holding different beliefs on policy and implementing conflicting business models. The result is a "chasm" between the system we now have to deliver health care and the system we want.[10] Nowhere do we feel these tension more strongly than when we bring together behavioral health and medical care.

A Line in the Sand: Bringing the Field Together for Collective Impact

To have a collective impact, the field of behavioral health and primary care must realize the different policy changes they need from their respective positions. Fundamentally, working to change behavioral health policy requires us to address a different set of rules than those found in other non-behavioral-health-policy initiatives. Although the mechanism for change may be similar, what needs to be changed is often not. Integration advocates must tease apart the policy in support of integration relative to those policies that may simply benefit behavioral health. The specialty mental health system exists, no matter how limited, to serve those who often have severe behavioral health needs. Many patients have shown with their behavior that they want their behavioral health needs met in primary care.[11,12]

As the data show, people with "poor behavioral health" attend more behavioral health visits in the specialty sector than those with less severe behavioral health needs who present in primary care.[12] However, in both cases, people are often not receiving minimally adequate treatment for their mental health. This suggests that those who need care the most are not accessing these services. Further, when patients are tracked across both specialty mental health and primary care settings, we see limited evidence to support collaboration.[13,14]

Two outcomes occur from the above phenomenon: 1) a compound effect on a patient's health and overall outcomes, and 2) an overall increase in cost related to not receiving timely treatment for issues that could have been addressed and/or mitigated. With the majority of health policy aiming to tackle the triple aim, these 2 outstanding issues present a substantial opportunity for the field around health policy. But the policy issues to address these problems must be looked at in isolation—broken down.

Health-Policy Recommendations

This Supplement provides policy makers with empirical evidence that there is an urgent need for new and revised policies to enable integrated care.[15] The following 3 areas are ripe for attention to help bring into alignment practice innovation with health policy.

Divided We Fall

To make more meaningful steps toward transformation, some uniting force must bring community innovators together. Neutral conveners are in short supply, and due to the inherent nature of competing interests when integrating care, are sorely needed. To change policy to support integrated care, there should be a "trellis" in each community that allows the disparate efforts to grow collectively toward a common goal. A united effort will be more likely to succeed when asking for legal, regulatory, and policy changes that reinforce innovative approaches to behavioral health in primary care.

Examples of neutral conveners are often found in the philanthropic community, a community that has frequently supported many integrated care initiatives across the country. At a local level, one may want to identify a philanthropic foundation that is willing to bring a community together around a common cause and policy goal.

At a national level, a health foundation convener such as Grantmakers in Health could provide strategic direction to the local foundation efforts and begin to make a larger, more coherent policy argument for federal reform. Bringing together all the unique stories from each foundation to 1 central location has the same effect as the local trellis, but on a larger scale.

One Size Does Not Fit All

We must examine policies that promote unfettered access to behavioral health services, regardless of

setting. This means that we must examine multiple policies to allow for more services for patients with behavioral health needs in every setting. Patients can continue to access services through the specialty mental health sector, but people whose behavioral health needs are identified in primary care should also be given the option to have their care addressed in that setting, too. The way the system is currently set up forces us to place people into arbitrary categories based on their diagnosis. We should pursue policies that better take into account a community's needs for behavioral health, and allocate the appropriate resources into the settings where patients are most likely to seek care.

States should examine the unintended consequences of contracts that carve out the behavioral health benefit on access, and purchasers of health insurance should examine how these same policies negatively affect the population they are trying to keep healthy.[16,17] To increase patient satisfaction in health care, we should examine policies around payment that artificially limit patient choice in where they choose to seek their behavioral health services.

The evidence from this supplement suggests that legacy systems and often antiquated payment policies limit primary care practices ability to provide integrated care. If 1 size does not fit all for behavioral health, there should be "no wrong door" for patients in our community when it comes to receiving care.[18] All health policies should be measured against the question, "Will this limit my patients' choice in receiving behavioral health where they want?" It will simply be impossible to answer this question with a yes and be in support of integrated care.

Data Integrates and Data Fragments

So much of making the case about integration hinges on our ability to collect data to make the case. These clinical, operational, and financial data, interestingly, are quite different between behavioral health and medical, which has created a huge barrier to supporting integrated care. Entire health systems, consisting of thousands of lives, have been built to treat (and collect data) on the piece instead of the whole. Being able to adequately capture who is reached by the intervention is a first step in creating an infrastructure that can show the effect of a truly integrated team. In addition, working with our communities on engaging in technology that better integrates rather than fragments is essential (eg, different medical records in behavioral health settings than those used in medical settings).

To demonstrate the effect of integration, we need policies that set a minimal criteria for which data are the most important for practices to collect. If there are different policies in place for behavioral health and medical, we will continue to see the challenge of connecting data and integrating care.

Policy and payment reform often go together, and single-handedly highlight the divide between behavioral health policy needs and medical or primary care policy. For example, those trying to scale integrated care consistently cite financial sustainability as 1 of the most profound barriers. But when behavioral health treatment, and therefore financing, is seen as "one size fits all" for any person with behavioral health, options around treatment are limited. This means that advocacy groups representing both behavioral health and primary care must recognize that to achieve policy change that benefits people, certain concessions must be made on both sides. This cannot be about protecting one's turf just because that is the way it has always been, but more about creating a culture of shared benefit whereby the patients ultimately win.

Although work continues to be done in the payment reform space, addressing the aforementioned 3 policy recommendations can achieve the collective effect our patients, practices, and providers all want. Payment reform will come to support our efforts when we begin to identify and make progress toward these recommendations.

To affect health policy, know the goal, make your case, and achieve collective effect, but most importantly, understand why changes in health policy are necessary—because innovators on the ground, integrating care, are changing lives and need help.

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