5 Value-Based Behavioral Health Strategies for ACOs and Medical Group Models

written by Theresa Hush | April 6, 2021

For ACOs and Direct Contracting Medical Groups adopting value-based payment models, behavioral health is often overlooked. But your patients' unmet behavioral health issues are a big cost driver for emergency care and inpatient admissions, and they compound risk factors in disease. They also influence your patients' adherence to treatment plans. You may believe this is a problem you can't resolve because behavioral health is beyond the boundaries of your participating network. Even so, you need to be aware of a significant emerging trend: integrating behavioral health in primary care.

The difference between physical medicine's approach to disease versus behavioral health is striking. For major diseases causing death and morbidity, the health care industry focuses intensely on creating better screening tools and reaching more people, making early diagnoses, and perfecting treatments. We turn to risk factor prevention and vaccinations to stop

incidence or progression of disease. For cancer care, cardiovascular conditions, diabetes, and COVID-19, our combined capacity to tackle the biggest health threats is profound when we believe that costs of delay and nontreatment are too high to ignore.

By contrast, behavioral health has all too often remained a secondary or unfamiliar consideration. Some health systems have begun to recognize the need to focus more attention on behavioral health and its ramifications for costs and outcomes. Is behavioral health part of your Value-Based Care strategies? If not, your inability to address these patient needs will have consequences. These include both direct outcomes for the patient and family—hospitalizations and suicides—as well as indirect outcomes for the patients' other conditions.

Continuing to ignore this aspect of total health has a huge societal cost, as well. Behavioral health underlies violence against others, financial crises, and homelessness. The plague of mass shootings in the U.S. is tied to behavioral health issues, too; although the vast majority of people with mental health issues are not violent, at least 40 percent of shooters have had previously identified mental health disorders, and many have histories of past personal trauma or unaddressed sociopathy and anger.

Payment models must support the integration of behavioral health in primary care. The Bipartisan Policy Center's March 2021 task force report on behavioral health integration outlines essentials for integrating behavioral health into the medical system; it's an excellent resource for ACOs to build integration models, to ensure a common core of standards, and

to collectively support payment reform. The report addresses the lack of available, licensed behavioral health providers in some regions, and the unwillingness of existing BH providers to accept insurance. To broaden the pool of professionals and expand their networks, ACOs and Medical Groups have an important, collective opportunity to solve this problem by advocating for changes in the payment system to encourage behavioral health services, as well as to permit alternative payment arrangements within the ACO, such as capitation and sub-capitated payments for specialists.

Five Strategies for Creating Behavioral Health Initiatives

Your ACO or Medical Group can develop strategies to address behavioral health and lower your potential risk under value-based payment models. The basic process is no different than for any serious medical condition, although larger in scale and involving a more diverse population. Here are five basic strategies to get you on the path:

1. Create models for behavioral health integration in primary care that the ACO/Medical Group can support with resources and data.

Integration of behavioral health care into primary care is essential for expanding patient services, but there are many models, ranging from behavioral health providers' inclusion in primary care practices, to separate practices that share management of patient care. Recent reevaluation by the Millbank Foundation highlights the emergence of a Coordinated Care Model using trained case managers to arrange joint management of

patients by behavioral health and primary care providers.

Which models work best in your organization will depend on your practices' varying resources, locations, and patient populations, so different models may be adopted by practices within ACOs having independent primary care practices. Pre-assessments of BH capacities, current attitudes, and expertise are vital to constructing an effective approach to selecting models. The ACO's role is not to dictate to practices the terms of integration models, but, rather, to define the standards for overall behavioral health integration and to encourage models that the ACO can support with services and technology.

Despite many efforts to reduce negative feelings about behavioral or mental health problems, research shows that these conditions remain a stigma for providers and patients alike. As a result, physicians are reluctant to assess and diagnose early, and patients do not speak freely; but failure to identify core BH issues can delay or eliminate the possibility of comprehensive and effective patient care. No matter where you start in your current culture, meeting your goals will depend on helping practices develop a high level of comfort with identifying patient needs during patient discussions, and then meeting their needs in conjunction with behavioral health professionals.

2. Adopt ACO/Medical Group technology, with data collection standards, to support BH Integration.

A flexible approach to BH integration in practice settings facilitates and requires a shared system that supports

practices with BH patient registries and population health tools. Collecting practice data in addition to claims—and expanding that dataset to include BH patient assessment data—is critical to evaluating and comparing costs, outcomes, and results of initiatives undertaken by practices. The technology should allow for practices to share comparative data on key performance metrics.

In many cases, this is a huge leap for ACOs, which have relied, at best, on claims data to fuel their initiatives. But that must change for ACOs to be able to evaluate outcomes and succeed in Risk by pursuing initiatives that go beyond administrative cost control.

A rich data foundation enables behavioral health episodes of care as well as integrated chronic disease/behavioral health episodes. Using episodes creates the capacity to compare patients in cohorts against each other and to make comparisons by provider, to reveal cost variation and to identify issues in patient care. By involving clinicians and direct patient care staff in shared data results on costs, outcomes, and measures of patient service, ACOs and Medical Groups can create common ground for improvement initiatives.

3. Implement ACO/Medical Group Behavioral Health assessments and reach consensus on pathways to treatments and referrals.

One of the most important functions your ACO can fulfill is the creation of common assessment tools and processes, with the help of BH clinicians and expertise. The primary benefit to your organization is facilitating standardized patient clinical

information and a stated standard of care. A shared approach also alleviates the burden—and disparities—associated with practices developing their own assessments or questions that could include biases that may dissuade patient honesty.

You can then proceed to foster more coordinated pathways for treatments and protocols for referrals among practices, incorporating tweaks informed by data from BH and chronic care episodes.

4. Implement training curricula across all practices, including cross-training strategies between behavioral health and primary care clinicians.

Some of the most innovative strategies to integrate BH into primary care involve shared training and exchanging expertise to fulfill needs in either BH or primary care. These can be as basic as involving behavioral health specialists in patient engagement, such as motivational patient interviews. Likewise, primary care clinicians can provide direction for complex medical situations involving behavioral health patients.

How cross-training materializes is largely dependent on the practice's chosen behavioral health integration model. The more distance between the parties, the less cross-functionality, requiring more coordinated planning.

Practices that have fully integrated behavioral health enrich patient care, providing patients a seamless and accepting environment to engage in both primary care and behavioral health management.

5. Establish outside BH referral sources for patients that require specialized expertise or facilities, or care that cannot be provided inside the practices through behavioral health integration.

To close the loop on behavioral health care, your ACO or Medical Group must formulate a referral network for patients who need specialized services. One important consideration is whether the partnering referral organization is willing to contribute data to your pool of patient data. While claims data from such referrals is available, it lacks evaluation and clinical information, including medications, that are part of the patient's treatment plan. This prohibits the ACO or Medical Group from including these details in patient episodes, leaving knowledge gaps that disable improvement strategies.

External BH referrals beyond the ACO's BH-integrated primary care practices include substance abuse treatment, treatment for severe psychoses and psychiatric disorders, and support for patients who fail to progress in treatment despite efforts. Creating this clinical behavioral health safety net is essential to providing good patient care; in some communities, however, it is very difficult due to lack of available resources, as well as limits on insurance acceptance or coverage issues.

This may sound like a heavy lift. It is also a major opportunity to be an agent for essential change. Your ACO may be in a prime position to catalyze better behavioral health care. ACOs and Medical Groups collectively can play a significant role as advocates for changes in payment models and

coverage to ensure that patients have access to these critical services.

It’s also good business. Taking on this set of strategies will improve your chances of success under Risk and ensure that your behavioral health programs improve patients’ outcomes and lower costs. Your organization will fulfill the promise of whole patient care that was envisioned, but never achieved, by other models, such as prior Medical Home and Medical Neighborhood initiatives. In sum, behavioral health integration’s triple play strengthens your ACO’s sustainability, supports your participating providers, and benefits your patients.

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