INNOVATIVE CARE DELIVERY:
Behavioral Health Integration and Home-based Primary Care

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AAFP

Providing Flexible Care Delivery Options

The shift to value-based payment (VBP) often focuses on physicians taking on more financial risk. In most VBP arrangements—commercial, Medicare, or Medicaid—the goal is to have more physicians engaged in risk-based payment models to meet the quadruple aim of better health of the patient population, better patient satisfaction, lower cost of care, and better primary care team satisfaction.

Foundational in shifting the health care system to VBP models is the flexibility in health care delivery that allows physicians to provide what the American Academy of Family Physicians (AAFP) refers to as the "quadruple right" of better health care. The AAFP proposes that the quadruple right consists of delivering the *right care*, to the *right patient*, at the *right time*, and in the *right location*.

In order to achieve the quadruple right, the goals of VBP should be inherently aligned and rely on implementing innovative care solutions. Examples of these solutions include behavioral health integration (BHI) and home-based primary care (HBPC)—concepts that are the focus of this supplement.

Behavioral Health Integration

Mental illness is prevalent in the United States.In the United States in 2019, the prevalence of any mental illness was approximately 51.5 million adults 18 years or older—nearly one in five adults.[1] Further, as many as 40% of patients seen by primary care physicians have a mental illness and the presence of psychiatric comorbidities,[2] with data suggesting that as many as 70% of primary care visits in the United States are related to behavioral health needs.[3]

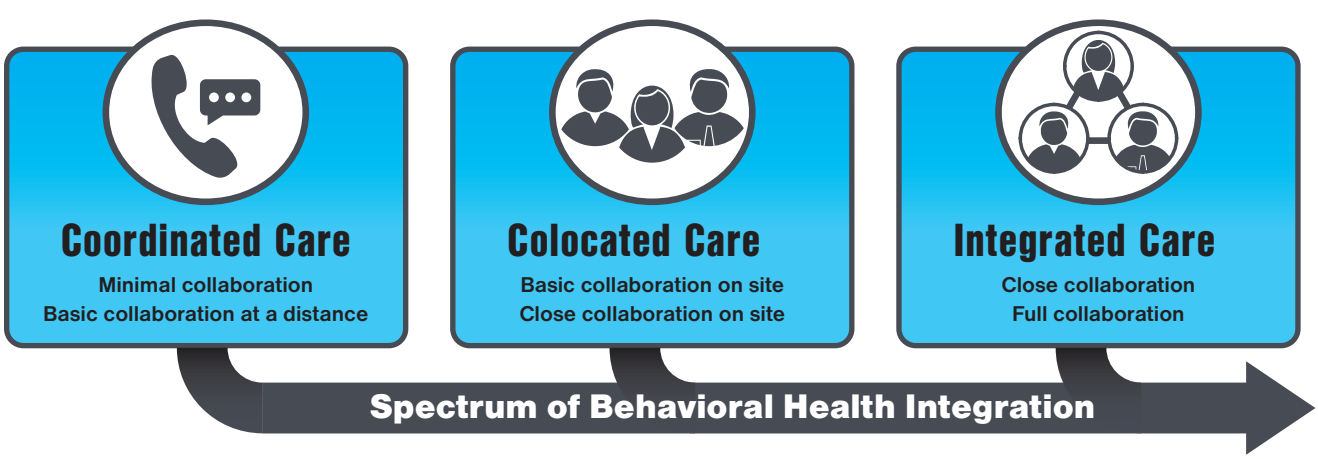
Patients who present with a physical health complaint may have a comorbid mental health need that prompts the visit or elevates the need for collaboration among other health professionals. However, lack of adequate financial support, resources, time, access, and appropriate staff may make meeting the mental and behavioral health needs of patients a challenge—particularly in the fee-for-service (FFS) environment.

The most common method of payment for behavioral health is FFS. Many practices are moving toward VBP and are beginning to leverage the care delivery and payment flexibilities available to them through alternative payment arrangements.

What is BHI?

BHI looks different for every practice and is a continuous process refined over time to meet evolving patient and practice needs. At its core, BHI is a patient-centered approach in which primary care and behavioral health physicians and other clinicians work together with patients and caregivers to improve the physical and mental health of the patient.

Six widely recognized levels of BHI fall into the three distinct categories illustrated below.[4]



Coordinated care entails minimal collaboration and/or basic collaboration at a distance. Primary care and behavioral health clinicians work in separate facilities, communicating information about shared patients to facilitate care.

Colocated care requires the primary care team and behavioral health specialist to be located within close physical proximity of each other (i.e., in the same facility, but not necessarily in the same office). It allows opportunities to discuss patient care through multiple modalities—including in person—and begins to build a larger team-based approach to patient care.

Integrated care requires practice change to create a systematic approach with close and/or full collaboration among patients, families, and the integrated health care team.

BHI and VBP

Most BHI is currently supported through FFS. However, moving along the VBP continuum may help support a practice's ability to move on the BHI spectrum toward care that is more integrated among care teams. Most practices begin implementing BHI in the FFS environment and have the ability to become more integrated as they take on VBP contracts with aligned payments and increased flexibility in care delivery.

BHI provides many benefits to patients, physicians, and payers. These include reductions in emergency department utilization and hospitalizations; improvements in patient outcomes and patient/practice satisfaction; and increased payment to physicians based on performance.[5]

An ideal alignment of BHI with primary care VBP models includes adequate prospective payment arrangements to support BHI at a level commensurate to the patient's needs.[6] This alignment is not the current reality in many cases, as family physicians often have payment arrangements with 10 or more payers, and there is rarely alignment in payment models and reporting requirements.

While one VBP model across payers may not be the solution, alignment of BHI with primary care VBP models (when possible) would provide the administrative simplification family physicians desperately need.

Another VBP model to consider for BHI is bundled payments, particularly to meet the needs of specific patient populations.[6] Examples of this model include the Center for Medicare & Medicaid Innovation's (CMMI's) Integrated Care for Kids (InCK) model for individuals under 21 years with behavioral and physical health needs[7] and the Maternal Opioid Misuse (MOM) model for Medicaid beneficiaries who are pregnant or postpartum with an opioid use disorder.[8]

Telehealth may be used for both FFS and VBP models to improve access in rural and underserved communities and address BHI challenges where there may be shortages of physicians and behavioral health specialists.

Home-based Primary Care

Health care costs are exceedingly high—even more so at the end of life—with approximately 25% of Medicare payments occurring during the last year of life.[9] Not only are health care costs increasing, but the population in the United States is aging, with the health system facing mounting challenges to ensure patients receive high-quality and cost-effective care.[10]

One major challenge is delivering care in new and innovative ways to a growing population facing mobility issues, such as patients[11]:

- who are unable to visit a physician's physical office;
- with functional impairments, disabilities, and/or multiple serious chronic conditions;
- who require end-of-life care; and/or
- who are not cared for by disease-specific management programs.

One estimate attributes 56% of all health care expenditures to individuals with functional limitations.[11]

HBPC and VBP

A major push of the VBP movement is to encourage new delivery models with incentives aligned to address rising health care costs. One promising solution is HBPC—defined as primary and palliative care provided in the home to patients who are at high risk or medically vulnerable. HBPC provides preventive care to avoid unnecessary emergency department utilization and inpatient hospitalizations through patient monitoring in the home, care management, and proactive interventions.[11] At a high level, HBPC identifies patients who would most benefit from home-based integrated care and provides the right set of services to meet patient needs.

Payers—including the Centers for Medicare & Medicaid Services (CMS)—have realized the value HBPC brings to patients and the health care system as a whole, and are investing in payment models to provide stable sources of funding for care teams serving patient populations with the most and costliest care needs.

In 2014, more than 2.5 million HBPC visits were made to patients enrolled in Medicare, Medicaid, dual Medicare-Medicaid, Medicare Advantage, and other commercial payers. It is estimated that two million Medicare patients could benefit from HBPC.[12]

Successful VBP models of HBPC include the U.S. Department of Veterans Affairs (VA), which operates 150 HBPC sites with 24% lower VA costs and 11% lower Medicare costs[13]; home care models used by several commercial payers (including Humana and Optum), which have improved performance measures such as patient satisfaction and reduced emergency department and hospital utilization[14]; and the Independence at Home Demonstration, which has delivered some small savings to Medicare.[15]

New models that allow flexibility of HBPC delivery are also being tested for populations with serious illnesses. CMMI has two models testing various risk levels for physicians interested in HBPC: Primary Care First – Seriously Ill Population[16] and Global and Professional Direct Contracting[17] (those serving high-needs populations). As more physicians transition to VBP arrangements that provide financial incentives and flexibility in care delivery, HBPC is an opportunity to provide the quadruple right of better health care—delivering the *right care*, to the *right patient*, at the *right time*, and in the *right location*.

AAFP Resources

The AAFP has resources to help identify patients who may benefit from innovative care solutions, including BHI and HBPC. The AAFP's Risk-Stratified Care Management Rubric (www.aafp.org/rscm-rubric) and Risk-Stratified Care Management Scoring Algorithm (www.aafp.org/rscm-algorithm) help identify patients who may need additional behavioral health resources or patients with high costs who may benefit from HBPC. The Practice Hack video on integrating the Patient Health Questionnaire-9 (PHQ-9) into your practice workflow can help you take steps toward achieving BHI.

References

Go to www.aafp.org/innovative-care-delivery to see a full listing of references.