The Permanente Journal *2007 "Service Quality Award" — Institute for Healthcare Improvement 19th Annual National Forum on Quality Improvement in Health Care*

Counseling and Wellness Services Integrated with Primary Care: A Delivery System That Works

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Introduction: The continuity and coordination of care between medical and behavioral health services is a major issue facing our health care delivery system. Barriers to basic communication between providers of medical services and providers of behavioral health services, include: no coordination of services, and poor recognition of the relationship between medical and behavioral issues.

Methods: Colocating behavioral health counselors and nutritionists alongside primary care physicians and clinicians (PCPs).

Results: Grand Valley Health Plan (GVHP) established the national benchmark for patients using ambulatory services for mental health, and ranked first in Michigan on all six HEDIS "effectiveness of care" measures for behavioral health. One result was a 54% decrease in mental health hospitalization.

Discussion: Up to 70% of primary care visits are driven by psychosocial factors, with 25% of patients having a diagnosable mental disorder, and comorbidity occurring in up to 80%. With colocated services, PCPs now often explain to patients that "this is just how we deliver care to you," when introducing health coaches to patients and asking them to be involved.

Fifty percent of all behavioral health care is delivered by PCPs,[4] ...

Background

The continuity and coordination of care between medical and behavioral health services is a major issue facing our health care delivery system.[1] There are barriers to basic communication between providers of medical services and providers of behavioral health services, there is often no coordination of services, and there is poor recognition of the relationship between medical and behavioral issues in the current health care delivery system.[2]

Grand Valley Health Plan (GVHP) is a staff-model health plan in Grand Rapids, MI, that has been integrating health care delivery in a team-based system for 25 years. Behavioral health counselors and nutritionists have always been employees of the health plan, along with family practice physicians, midlevel practitioners, and other staff providing primary care services in family health centers. The focus of these counseling and wellness services and how those services have been delivered has varied, and at times, despite being part of the same organization and same team, the services still were not well integrated. The services provided by behavioral health counselors and nutritionists were not always well coordinated with primary care physicians and clinicians (PCPs), and traditional counseling models and hour-long appointments were being used by the behavioral health counselors and nutritionists. PCPs would also commonly treat patients with psychotropic medications without involving the behavioral health counselor. For a brief period of time, counseling and wellness services were provided in two centralized locations, but this resulted in much higher no-show and cancellation rates as well as less communication between counseling and wellness staff and the PCPs.

Purpose of Study

In 2002, GVHP had poor performance in many behavioral health measures, including high rates of mental health hospitalizations and poor HEDIS scores. We also recognized the challenge of transforming our system from the inside out and to more fully integrate

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counseling and wellness services into primary care. As a result, GVHP formed an interdisciplinary task group to redesign counseling and wellness services. The stated goal was to have population-based counseling and wellness services integrated into the GVHP group practice that targets patients at high risk, focuses on behavior change, and effectively expands the number of patients receiving services.

GVHP hired a consultant from Mountainview Consulting Group, Inc, who specializes in the integration of behavioral health with primary care, to assist us in this redesign. We focused on the following basic principals and assumptions:

- The medical system is the de facto mental health system in the US.[3] Fifty percent of all behavioral health care is delivered by PCPs,[4] and only about 6% of the population seeks behavioral health treatment in a traditional behavioral health setting.[1]
- Patients receiving care in our health center have mental health issues but also other lifestyle and behavioral issues that affect their health. It has been found that 25% of patients receiving primary care services have a diagnosable mental disorder[5] and that mental disorders frequently co-occur with other mental or physical disorders. Estimates of this comorbidity range from 20% to 80%.[6] In addition, it is estimated that up to 70% of primary care visits are driven by psychosocial factors.[7] Our own experience at GVHP has been that the mind–body connection influences a high number of primary care visits and that patients with medical diagnoses and disease often have behavioral and lifestyle factors that increase their risk. Patients may struggle with compliance, lack good support, have limited resources, or may have anxiety or depressive symptoms that are barriers to appropriate response and consistent management of their condition.

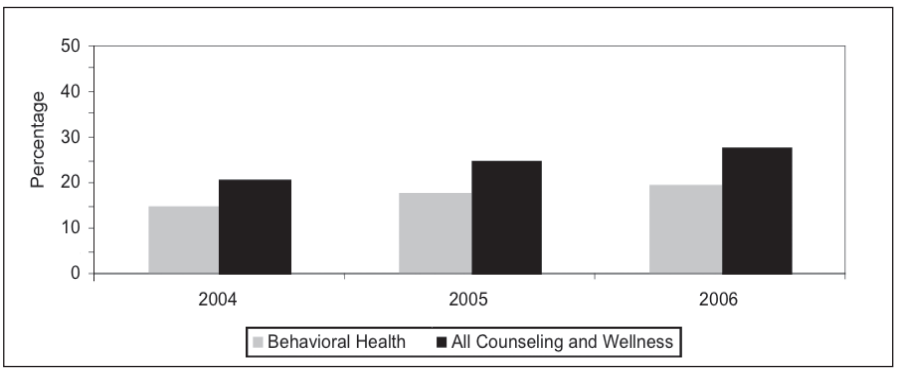

Figure 1. Percentage of Grand Valley Health Plan patients seen by counseling and wellness staff in primary care (internal data).

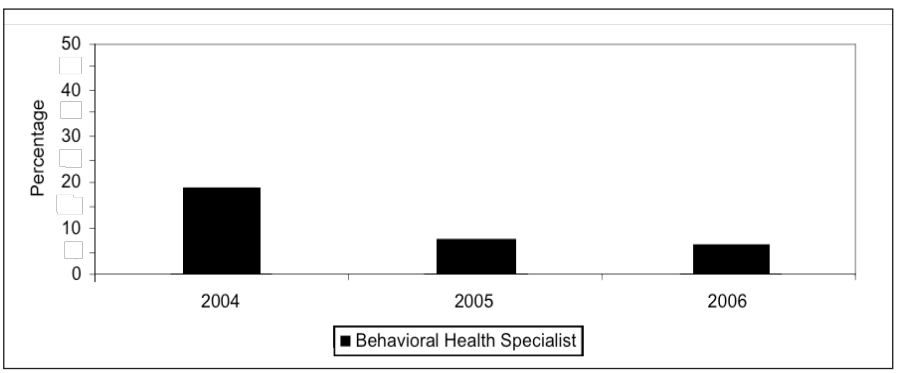

Figure 2. Percentage of Grand Valley Health Plan patients referred to behavioral health specialist (internal data).

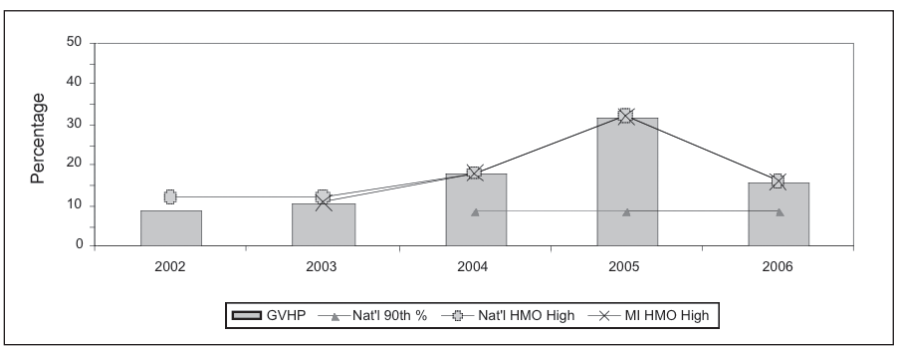

Figure 3. HEDIS patients receiving ambulatory mental health services.
GVHP = Grand Valley Health Plan; HMO = health maintenance organization; MI = Michigan.

Methods

The redesign of services, implemented in September 2003, had the following components:

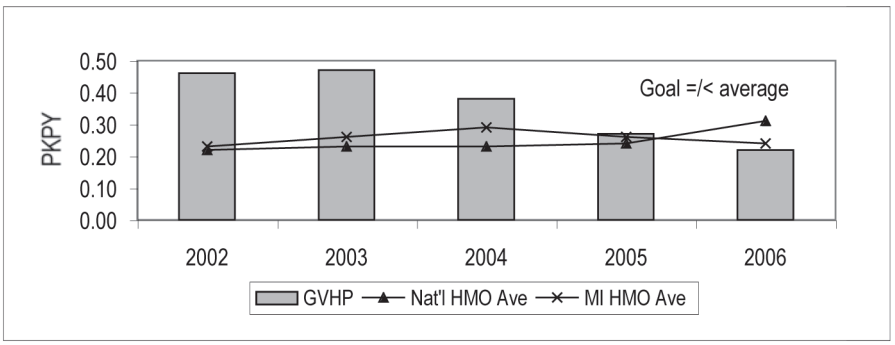

Figure 4. Patients receiving inpatient mental health services (National Committee for Quality Assurance HEDIS).

GVHP = Grand Valley Health Plan; HMO = health maintenance organization; MI = Michigan; PKPY= per thousand per year.

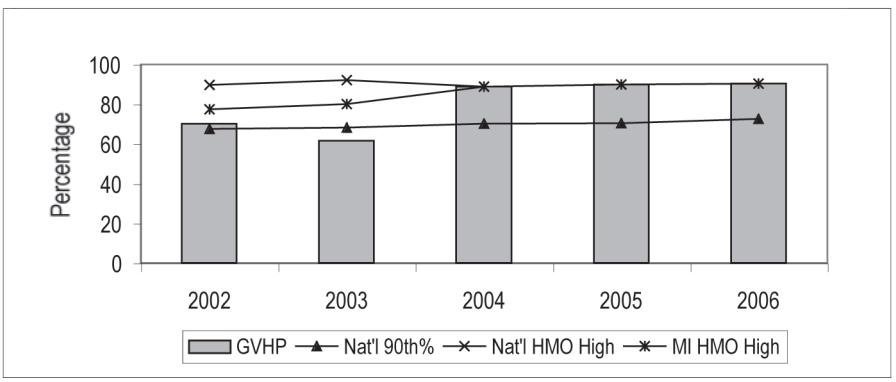

Figure 5. HEDIS mental health hospitalization follow-up in seven days.

GVHP = Grand Valley Health Plan; HMO = health maintenance organization; MI = Michigan.

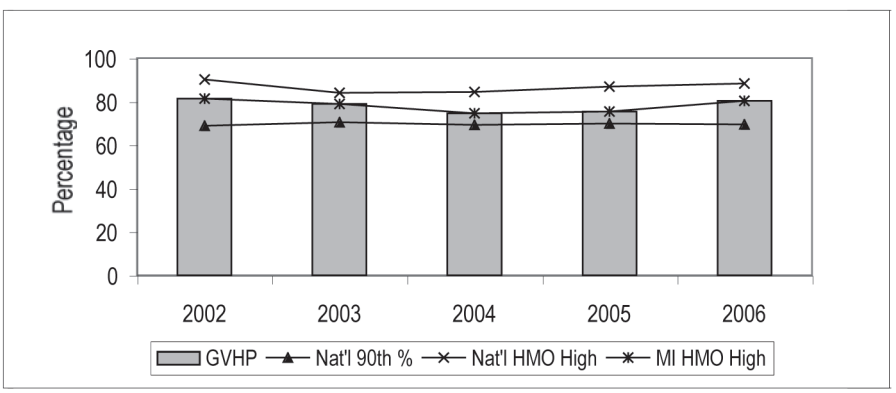

Figure 6. HEDIS antidepressant acute-phase treatment.

GVHP = Grand Valley Health Plan; HMO = health maintenance organization; MI = Michigan.

- We implemented colocation of counseling and wellness (C&W) staff (behavioral health counselors and nutritionists) in all GVHP health centers and placed their workstations alongside those of PCPs
- We began calling C&W staff *health coaches*
- We established 15- to 30-minute appointments for C&W staff to provide timely access for patients and PCPs
- We provided targeted training for health counselors and PCPs in the new model and the techniques and skills to implement it
- We established 50% of daily C&W appointments as same-day appointments
- We provided basic triage, assessment, consultation, and health counseling to patients at their health centers
- We established evidence-based care guidelines for the delivery of C&W services
- We focused on services for traditional behavioral health and dietary issues but also on lifestyle and behavior factors that impact patients' health and management of disease.

Barriers

Implementation of this model required a paradigm shift by C&W staff accustomed to providing care in traditional settings and models of care. Staff reported that it was difficult to begin to call or view themselves as a health coach rather than a therapist or counselor. Moving from the traditional 50-minute sessions to 15 to 30-minute appointments required a very different approach to interviewing and intervening with patients. This model also required shifts by clinicians who were not accustomed to sharing patients and who were used to making referrals to C&W staff only for quite traditional behavioral health or dietary issues. There was high variation in PCP patterns of screening for behavioral health issues during primary care visits, and it was difficult to get PCPs to more consistently screen patients for behavioral health and lifestyle issues. This meant both training and mentoring them about expanding not only what questions to ask to better screen for mental health

conditions but also their view of the types of patients who could benefit from C&W services.

Results

The impact of integration has been substantial, with the intended result of more patients being seen by C&W staff, improved access, and improved quality of care. There were also results that were not targeted or anticipated, such as improvements in all measures relating to mental health hospitalizations. Some highlights are as follows:

- GVHP's C&W staff saw 26.7% of the total health plan membership in 2006 (Figure 1)
- GVHP primary care behavioral health counselors were able to treat more patients at the primary care level, resulting in significantly fewer referrals to behavioral health specialists (Figure 2)
- GVHP was ranked first in Michigan on all six effectiveness of care HEDIS measures for behavioral health (Figures 3–8)
- GVHP more than doubled access to and use of services by patients in three years and established the national benchmark for patients using ambulatory services for mental health (Figure 3)
- GVHP's mental health hospitalization rate decreased by 54% since 2002 (Figure 4).

From a financial standpoint, GVHP has made a financial commitment to this delivery system in having C&W staff as salaried employees of the health plan. A full cost analysis has not been made, but cost savings have been seen in lower hospitalization costs and fewer specialty care referrals. The medical cost savings has not been analyzed in terms of offset from lower medical costs.

Conclusions

With barriers to communication and coordination of care removed, medical and C&W services have become much more integrated at GVHP. The use of C&W services has been significantly increased for health plan members and PCPs are recognizing the benefits of using the skills of the C&W staff. This has also led to positive outcomes and supports the evidence that integration has improved the quality of care. GVHP is a leading performer on most behavioral health measures used by health plans. In addition, we believe that patients' general health care is also being affected by using C&W staff to work with patients on behavioral change as it relates to various disease states and chronic conditions. PCPs often explain to patients that "this is just how we deliver care to you" when introducing health coaches to patients and asking them to be involved.

GVHP has made a philosophical and financial commitment to this integrated model of care delivery. We have found it necessary to operate health centers consistently with C&W staff to maintain this approach to care, and this is a significant financial investment. Philosophically, you cannot use this approach part time. Many PCPs now have the expectation that health coaches will be avail-

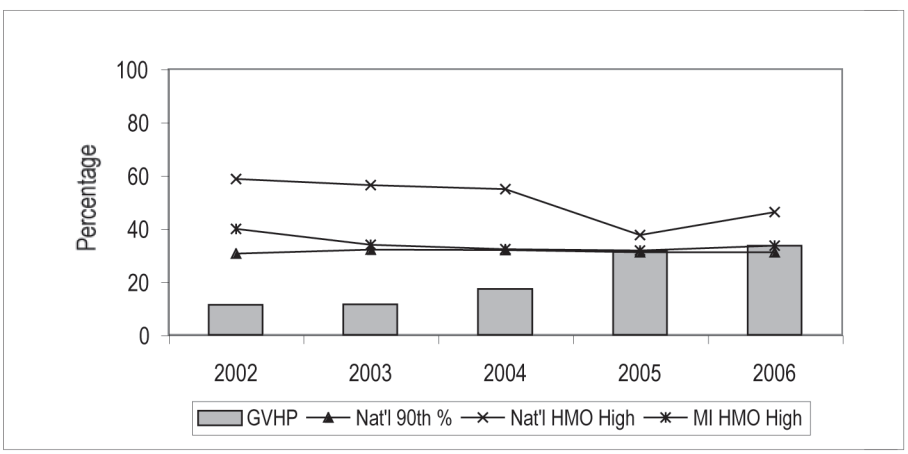

Figure 7. HEDIS antidepressant optimal contacts.
GVHP = Grand Valley Health Plan; HMO = health maintenance organization; MI = Michigan.

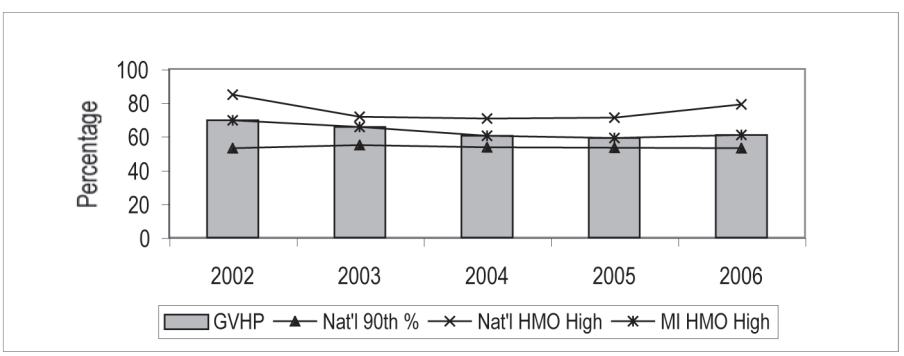

Figure 8. HEDIS antidepressant continuation phase treatment.
GVHP = Grand Valley Health Plan; HMO = health maintenance organization; MI = Michigan.

able for consultation.

GVHP continues to try to penetrate further into its health plan membership. The current focus is on patients in population-based programs and other high-risk populations who can be better treated using this integrated-care model. If at least 50% of the patients seen in primary care have psychosocial issues affecting their health, our goal is to continue to use our integrated model to provide timely and targeted services that will lead to quality outcomes. ❖

This article is based on the 2007 winner of the Institute of Healthcare Improvement Poster Award in December 2007 in Orlando, Florida.

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgment

Katharine O'Moore-Klopf of KOK Edit provided editorial assistance.

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The Hidden Ingredient

The human body experiences a powerful gravitational pull in the direction of hope. That is why the patient's hopes are the physician's secret weapon. They are the hidden ingredients in any prescription.

— Norman Cousins, 1915-1990, American editor and author