

Integrating Behavioral and Mental Health Services into the Primary Care Setting

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Internationally, nationally, and within North Carolina there is movement to more fully integrate physical and behavioral health care. One-fourth of the population has a diagnosable mental health condition, and half of those individuals with a serious illness will receive no mental health treatment.^{1,2} The Substance Abuse and Mental Health Services Administration (SAMHSA) director, Katherine Power, has described this as a public health crisis.² Approximately one in five children and adolescents will experience the signs and symptoms of a DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) disorder during the course of a year.³ 67% of psychoactive agents and 80% of antidepressants are prescribed by primary care providers.⁴ 92% of all elderly patients will receive mental health care from primary care providers.⁴ A staggering 70% of all patient primary care visits are related to behavioral health needs.^{4,5}

Rational for Integrated Care

Primary care can provide access to mental health services that are affordable and generate favorable health outcomes, and the World Health Organization promotes the integration of mental health into the primary care setting.¹ The federal government's senior workgroup chaired by the Assistant Surgeon General has reviewed the activities of multiple federal departments with regards to what specific activities are occurring to support integrated care. Their work highlights significant movement within the VA and several branches of the military.⁶

The North Carolina Foundation for Advanced Health Programs, Inc. has developed the ICARE Partnership. The Foundation's goal is to create a health care system that is Integrated, Collaborative, Accessible, Respectful, and Evidence-Based (ICARE).⁷ Partners include professional associations and other key stakeholders who have joined together to increase access to quality, evidence-based behavioral health care services for North Carolinian's citizens. The Office of Rural Health and Community Care, through its Community Care of North Carolina (CCNC) program, provided startup funds to over 50 primary care practices interested in bringing a new behavioral health

provider into practice. The types of practices varied greatly and included pediatric, family, and internal medicine, health departments, community health centers, and rural health centers. CCNC did not dictate a model since significant differences exist for the practices among insurance carriers, patient populations, workforce availability, and access to specialty mental health services. Over the past 18 months, practices have provided quarterly clinical and financial data. It is through CCNC's work to support these primary care providers and the behavioral health providers (BHP) that several lessons have been learned.

Tendency to Adopt Specialty Mental Health Systems of Care

It is critical to remember that primary care generally provides services to a large number of individuals that are low in cost. This leads to high numbers of individuals being served with brief interventions of generally 15 to 30 minutes. When additional services are needed, patients are moved up the continuum of care to a higher intensity of services. Professionals from the current mental health workforce are skilled in specialty mental health care. They are accustomed to providing high intensity of services to low numbers of patients. They have considerable knowledge about comprehensive mental health assessments, physiological testing, and an

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array of therapy modalities. In addition, they are familiar with the billing and coding information necessary to support these specialty services. CCNC sees evidence of this when reviewing quarterly reports from the primary care practices. It is not uncommon to see the BHP coding for 40 to 50 minutes of individual psychotherapy three times as often when compared to the code for 20 to 30 minutes of individual psychotherapy.

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In CCNC's baseline survey, primary care providers reported being most comfortable with the treatment of attention-deficit/hyperactivity disorder (ADHD), adult depression, and anxiety. They were least comfortable with schizophrenia, other psychotic disorders, bipolar disorder, personality disorders, eating disorders, and dual or mixed diagnoses. It is understandable that providers would refer the most complex patients to the new BHP.

There are concrete reasons that, without careful attention, BHPs when placed into the primary care setting will default to known roles and responsibilities, resulting in the co-location of specialty mental health. The goal of the grant is to break down silos between mental health and primary care. A BHP on site is a first step in that process, but services can remain separated within the practice. Integrated care is a new and evolving method of care—one in which behavioral health becomes a routine component of primary care.

A Model for Primary Care

As CCNC moved further into implementation, an integrated model was promoted in keeping with the one outlined by the US Bureau of Primary Health Care for community health centers. This lays out a model in which the BHP sessions are generally limited to one to three visits, with clinical pathways for common mental health conditions expanding sessions to four to eight appointments, each generally 15 to 30 minutes in length.⁴ Such a BHP will have a much stronger focus on services that are team-based, provided on the same day, in support of primary care providers, and with a strong self-management component.

A statement from the American Academy of Family Physicians (AAFP) supports key recommendations from the Institute of Medicine of the National Academies and the Chronic Care Model and speaks to the steps that AAFP is taking to change the current system of care.⁸ Highlighted in the AAFP's presentation to the House Committee on Ways and Means are key components that integrated care can support, such as promoting behavioral changes, assisting patients with self-management, developing integrated systems of care, and linking providers with community resources.⁸

Considering that 70% of all patient primary care visits are related to behavioral health needs,^{4,5} a behavioral health provider can be used as a member of the team for substantially more than specialty mental health. Primary care practices can create meaningful opportunities to assist patients and their families in developing self-management plans for nutrition, exercise, tobacco cessation, chronic conditions, pain management, substance use, medication adherence, and improve childhood social-emotional development, if the vision for the behavioral health provider's role is expanded. This model will require both the medical and the behavioral health provider to move beyond their traditional roles as new clinical pathways are developed, team care is operationalized, and cross-training of disciplines occurs.

The Use of Evidence-Based Screenings

There are several recommendations for the integration of evidenced based screening into the primary care setting. The American Academy of Pediatrics' preventive health care recommendations call for psychosocial/behavioral assessment at all ages and that assessment for alcohol/drug use be included at ages 11-21 years.⁹ The US Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up,⁸ and the screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.^{10,11} For substance use SAMHSA recommends Screening, Brief Intervention, Referral, and Treatment (SBIRT) in the medical setting.¹²

To date, our primary care practices have reported the adoption of evidenced-based screening tools. Listed below are the most commonly used tools. Table 1 provides the websites for practices interested in acquiring them.

- Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)
- Beck Anxiety Inventory (BAI)
- Beck Depression Inventory-II (BDI)
- Conners Rating Scales-Revised (CRS-R)
- Edinburgh Postnatal Depression Scale (Edinburgh)
- Generalized Anxiety Disorder 7-item Scale (GAD-7)
- Guidelines for Adolescent Preventive Services (GAPS)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Patient Health Questionnaire Screeners (PHQ 2 and 9)
- Pediatric Symptom Checklists (PSC and Y-PSC)
- Vanderbilt ADHD Diagnostic Parent Rating Scale (Vanderbilt)

Implementing screenings and clinical pathways in the primary care setting for common mental health conditions such as depression, anxiety, and ADHD prove to be difficult if a specialty model is well entrenched. The volume of referrals outpaces the systems design, particularly if the BHP is employed by a specialty mental health agency that requires extensive intake. Adopting these recommendations, in addition to being evidence-based, will promote a model that requires brief intervention and treatment, self-management, and referral. Clinical pathways require that all of the practice's clinical teams examine their role in improving the quality of care for these disease states.

The BHPs within the primary care setting report that their interventions to date have been targeted toward a wide range of diagnoses that include at-risk children (34%), depressive disorder (16%), ADHD/ADD (12%), episodic mood disorder (11%), anxiety (9%), adjustment reaction (7%), major depression (3%), and small percents for targeted diagnoses such as post-traumatic stress syndrome, bipolar disorder, and schizophrenia.

Table 1.
Evidence-Based Screening Tools

These assessments (many of which are free) can be acquired through the following websites:

Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)

<http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

Beck Anxiety Inventory (BAI)

<http://pearsonassess.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8018-400&Mode=summary>

Beck Depression Inventory-II (BDI)

<http://pearsonassess.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8019-415&Mode=summary>

Conners Rating Scales-Revised (CRS-R)

<http://www.pearsonassessments.com/crsr.aspx>

Edinburgh Postnatal Depression Scale (Edinburgh)

<http://www.dbpeds.org/articles/detail.cfm?TextID=485>

Generalized Anxiety Disorder 7-item Scale (GAD-7)

<http://archinte.ama-assn.org/cgi/content/full/166/10/1092>

Guidelines for Adolescent Preventive Services (GAPS)

<http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health/guidelines-adolescent-preventive-services.shtml>

Modified Checklist for Autism in Toddlers (M-CHAT)

<http://www.dbpeds.org/articles/detail.cfm?TextID=466>

Patient Health Questionnaire Screeners (PHQ 2 and 9)

<http://www.phqscreener.com/>

Pediatric Symptom Checklists (PSC and Y-PSC)

http://www2.massgeneral.org/allpsych/psc/psc_home.htm

Vanderbilt ADHD Diagnostic Parent Rating Scale (Vanderbilt)

http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp

Resources for Practices Interested in Integrated Care

CCNC networks and practices frequently request tools and resources that could assist them with implementation. The following websites and books warrant further review as they discuss both mental and behavioral health services from a medical perspective.

- *A Curriculum for Community Health Centers on Integrating Primary Care and Behavioral Health Services*⁴ provides a good overview for any primary care practice.
- *Integrated Behavioral Health in Primary Care: Step by Step Guidance for Assessment and Intervention*¹³ is a very comprehensive book with tools treatment of medical, behavioral, and mental health conditions that can be used by both medical and behavioral health providers.
- The ICARE website posts clinical trainings, evidence-based clinical pathways, screenings for mental health/substance abuse, and tools for billing/coding. ICARE's services and provider tools can be found online at <http://www.icarenc.org>.⁷
- Mountain Area Health Education Center website has a section dedicated to integrated care¹⁴ and in prior years has offered a certificate in integrated care for BHPs employed in the primary care setting.

- SAMHSA's SBIRT Model¹² lays out a brief model that can be used by both medical and behavioral health providers in the primary care setting to address substance use.
- The Air Force manual on integrated care.¹⁵

Strong Referral Relationships

Where the opportunity exists, it is recommended that primary care providers develop partnerships with local mental health providers and agencies just like they do with other medical professionals so that, when appropriate, patients can be moved across the continuum of care. Unstable targeted patients should receive the enhanced services that only a mental health agency can provide. Some communities have sponsored "meet and greet" evening events between primary care and specialty mental health providers, which they report as very productive.

It is a wise investment, regardless of the model, to develop a streamlined referral and communication process. In some communities, these new collaborations are creating access to psychiatric consultation, telemedicine, mobile crisis units, wrap-around services, and mental health case managers. It is important to acknowledge that a few of our practices report that their BHP is the only mental health resource in their community. In such cases the challenge is limiting services to only the practice's primary care patients.

Financial Considerations

Providing brief behavioral health interventions during the same visit has financial benefits. The most obvious is that the patient will keep the appointment (several practices in which the BHP had a separate appointment schedule or referral process reported problems with patients not keeping the appointment).

In a more fully integrated model, the medical provider can introduce and hand-off the patient to the BHP during the appointment. The BHP assists with screening, diagnosis, brief interventions, and the development of a self-management plan. Providers move on to assist other patients, returning to finalize the plan of care. This allows for additional practice efficiencies such as increased provider productivity.

It is important that the BHP can be interrupted so the provider, at a minimum, can introduce the BHP to the patient. This “warm hand-off” results in 85-95% of the patients entering treatment versus just 10% in the regular referral system.¹⁶

Some primary care practices report spending significant amounts of uncompensated time on case management and commitment activities. When available, it is clear that patients needing high levels of mental health support should be served in the specialty mental health system. Resources have been allocated to provide these wrap-around services.

It should be noted that in the integrated model, when clinical pathways call for follow-up clinical monitoring with parents, school systems, or patient by phone, these remain uncompensated activities.

The Devil is in the Details

It is critical to involve all players within the practice in the planning process. This should include clinical and business staff so that all involved understand the billing infrastructure needed to financially support the clinical model. Funding is a moving target and can vary greatly based on the type of practice, patient characteristics, and insurance type. We asked our providers to self-report on their patient panel and learned that collectively our pediatric practices reported, on average, 55% of their patient population had Medicaid, followed by 31% private insurance, whereas family practices reported 34% with private insurance, 25% Medicare, and 22% Medicaid. Consider the points below and how this information would influence a practice’s decision about the type of professional to be hired, how the billing process will work and determining what clinical services can be provided.

- It is important to know if a BHP is already paneled with the practice’s major carrier. If not, is that specific carrier accepting new providers into their panel? Some BHPs reported being informed that the insurance carriers’ mental health panel was full. In other cases, the carriers carve out mental health services.
- Medicaid has different prior authorization policy for children than adults.¹⁷

- Medicare has a narrow set of disciplines that can bill for services and in some cases it varies by code.⁷
- Medicare currently has a higher co-payment for therapy services than for medical services.¹⁸
- Both Medicare and Medicaid allow for incident to billing when the BHP meets criteria.^{16,17}
- Medicaid allows most practice types to bill for an evaluation and management (E/M) and a therapy code on the same day.¹⁷ However, policy change is in process for community health centers and CMS-sponsored rural health centers to bill same day. This is a key component to integrated care.
- Medicaid has recently opened new codes to support team based integrated care. Services are covered when provided by the physician or incident to the physician by a qualified BHP.^{19,20} Medicare has similar codes; however it also has policies that differ from Medicaid.⁷ It will be important to ask private carriers about their coverage and policy for these services.
- Smoking and tobacco use cessation counseling visits.
- Alcohol and/or substance (other than tobacco) abuse structured screenings.
- Administration and interpretation of health risk assessment instruments (i.e., depression screening).
- Health and behavior assessments (must provide medical ICD-9 code and focus on behavioral health that impacts physical health/chronic conditions).
- Detailed coding information for Medicaid and Medicare can be found on ICARE’s website under provider tools in the billing and coding subsection.⁷ In addition, ICARE can provide practice-based technical assistance for billing and coding.
- As a general rule, uninsured individuals do not have coverage for mental health care. It is important for the BHP to work with your county’s Local Management Agency (LME) as they have access to some resources for uninsured high risk patients that have targeted mental health conditions.

Moving Forward

The federal government and several states are moving to develop systems of integrated care and North Carolina is poised to be one of the leaders. Providers are expressing interest and high levels of satisfaction. They are adopting evidence-based tools and their patients are reporting improvement in their overall functioning. Providers should review the literature to ensure that clinically and operationally they implement a model that fits well within the design of their practices and maximizes the opportunity to improve clinical outcomes for all their patients. It is new ground, so it is likely that a practice’s model will evolve over time. It will take commitment and attention if the practice wants to optimize the outcomes integrated care has to offer.

Given the tight economic reality of most primary care practices, one can anticipate that they will logically proceed

with the elements or models that offer the greatest budget neutrality. North Carolina must move forward to align resources so that the model best suited for primary care is enhanced and properly funded. To this end, we must have the support of all payers.

The Federal Government appears, at many levels, to be making a substantial commitment to integrated care and their work could serve as a guide to North Carolina.⁶ Real commitment is necessary to support ICARE, their partners, and the primary care practices in their efforts to implement evidence-based care. Clinical training is needed for the existing workforce and educational institutions to develop

new programs for both primary and behavioral health providers.

Integrated care offers an exciting opportunity to build models in which behavioral and mental health are key components of overall health. It does not replace the need for specialty mental health and substance abuse services.¹ But if we are attentive to clinical guidelines, policy, and payment, we can realign resources to promote a system of care that, at the primary care level, incorporates self-management, behavioral change, and disease prevention, and where mental health and substance abuse are identified early and treated with parity like any other chronic condition. **NCMJ**

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