

# Integrating Behavioral Health and Primary Care: Persistent Challenges and Potential Solutions

Primary care is an essential access point for much needed behavioral and mental health care in this country. There is clear evidence that integrating behavioral health and primary care works, but it is not a prevalent practice. Indeed, it has been sparsely adopted.

On May 20, NEHI facilitated a discussion among experts who have been working on integration issues for much of their careers to bring further clarity to what successful integration entails and to develop points of collaboration around priorities to advance adoption and sustained implementation. This is our summary of the panel's discussion.

## Panelists:

- Nora Dennis, MD, MSPH,  
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Blue Cross and Blue Shield of North Carolina
- Ann Greiner, MCP,  
*President and CEO, Primary Care Collaborative*
- Lindsay Henderson, PsyD,  
*Director of Psychological Services, Amwell*
- Joshua Israel, MD,  
*Medical Director of Behavioral Health, Aledade*
- Katherine Knutson, MD, MPH,  
*Senior Vice President, United Health Group;*  
*CEO, Optum Behavioral Care*
- Virna Little, PsyD, LCSW-R,  
*Co-Founder and Chief Operating Officer,*  
Concert Health
- Benjamin Miller, PsyD,  
*Chief Strategy Officer, Well Being Trust*
- Christopher Molaro, MBA,  
*CEO and Co-Founder, NeuroFlow*
- Diane Powers, MBA, MA,  
*Co-Director, AIMS Center at the University of*  
*Washington School of Medicine Department*  
*of Psychiatry and Behavioral Sciences*
- Matthew Press, MD, MSc,  
*Physician Executive, Penn Primary Care;*  
*Medical Director, Primary Care Service Line,*  
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- Hyong Un, MD,  
*Chief Psychiatric Officer and Head of Product*  
*Innovation, Aetna Behavioral Health*

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### Resources from our Sponsors

- 3 case studies on Acute Behavioral Health programs:  
[Shannon Medical Center, Dignity Health, Cleveland Clinic](#)
- [FAQs](#) on the collaborative care model
- [Learn more](#) about Amwell's Psychiatric Care services.
- NeuroFlow's video: "[Support your Shift to Collaborative Care](#)"
- A [Case Study](#): How Jefferson Health Reduced ED Utilization by 34% with Behavioral Health Integration.
- White paper on the "[The Missing Piece of Behavioral Health Integration](#)".
- Article on "[The Foundations of Collaborative Care](#)" by NeuroFlow CEO, Christopher Molaro.
- Amwell's Behavioral Health [telehealth module](#).

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# NEHI Webinar Summary

For those of you who stayed with us for 2.5 hours, for those of you who found the recording and journeyed through it, and for those who could not make it but who want to know more about how to address the growing need for mental and behavioral health care, here are our top 10 webinar “take-aways”. We welcome your questions and feedback and, especially, your interest in continuing to explore how to integrate behavioral and medical care as part of what primary care is all about. **PLEASE SEE THE OBSERVATIONS AND NEXT STEPS SECTION ON PAGES 5 AND 6.**

## Introduction

- 1 Access to behavioral and mental health is inadequate. Demand for care far outpaces the supply of behavioral health providers and it is inconceivable that behavioral health clinicians will be able to meet a growing need for care.
- 2 The integration of behavioral health services in primary care offers a critical access point.
- 3 There is undisputed evidence that the Collaborative Care Model (CoCM) works (more than 80 RCTs over the last three decades). Panelists who implemented CoCM confirmed its effectiveness in improved clinical outcomes (e.g., reduction in PHQ-9 scores), fewer Emergency Department visits, reduction in provider “burn out,” decreased overall costs and positive ROI.
- 4 There is significant guidance on how to implement CoCM including playbooks to guide primary care practices in adopting the essential elements of the model.
- 5 Notably, all experts agree that, despite the evidence regarding its value, we are far from achieving the goal of widescale adoption of integrated behavioral health in primary care.

## The Issues; Partial Solutions

- 6 Culture eats strategy for breakfast (or lunch).
  - The healthcare system has historically segregated physical and behavioral health services (e.g., behavioral health managed care carve-outs)
  - It is a paradigm shift to say that primary care should be focused on “whole person care,” including mind and body. As several panelists put it: you cannot deliver primary care without taking care of your patients’ mental health. The integration of behavioral and primary care is a critical approach to support this paradigm shift.

- But primary care practices feel overburdened and underpaid. Referral of patients to specialty providers often seems to be the only viable option.
- In addition, some behavioral health clinicians and primary care physicians do not have the experience or interest in working together as an integrated team. Few primary care or behavioral health providers are trained to work with each other, and their backgrounds and practice approaches differ. Also, in many cases, there is uncertainty about what can be shared regarding the confidentiality of behavioral health records.
- Clinical champions are needed to drive the culture change required for integration to be successful.

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Clarifying the essential elements of evidence-based integrated behavioral health care is critical, even as other points of access to behavioral health care are also needed

- The “Collaborative Care Model” (CoCM) is generally the term used for the approach developed initially by the University of Washington that requires the inclusion of several components (e.g., accurate diagnosis, measurement, team-based care, and quality improvement). There are other forms of integrated behavioral health care that encompass some of these components, but it remains unclear how much “flexibility” in implementation is advisable and there remains disagreement on this point. Studies have principally reported outcomes based on the CoCM, which has been the most extensively researched integrated model.
- Other ways to provide access to behavioral healthcare through primary care, including PCP referrals to BH clinicians working within the PCP’s office (co-location) or outside the office, as well as through tele-behavioral health support are alternative approaches which could be adopted as early steps on the path toward integrated behavioral health care. Even though these are not generally viewed as desirable endpoints because they do not incorporate fundamental elements of evidence-based care, they remain necessary in the current environment. Tele-behavioral health support can also be incorporated as an important enabler of integrated care.
- By focusing on patients with mild to moderate behavioral health conditions, integrated behavioral health care frees capacity of psychiatrists and other behavioral health specialty providers to manage patients with more serious behavioral health issues. It is worth acknowledging that some patients enrolled in integrated models may still require access to these more specialized services, but on a more limited basis.

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Technical challenges are significant and require attention. The right IT systems are important for standardized assessments, measurement, coding, and billing. Turnkey market solutions, such as those offered by several of the panelists, are promising and can address some of these requirements of the collaborative care model.

- Given the significant investment required to implement the integrated model, serious consideration should be given to the “buy” vs. “build” option.
- Although some vendor solutions can be embedded in a practice’s electronic health record, continuing efforts to improve interoperability among health information systems will make these solutions more accessible.

- Efforts to move beyond a vendor relationship to a partnership (e.g., with shared ownership of processes and decisions) may enhance adoption of these solutions. Changes in the billing and payment arrangements are an important aspect of this journey.

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Financial feasibility continues to be cited as a barrier to adoption of integrated behavioral health care. That said, use of the collaborative care codes has enabled practices to maintain and grow utilization of the model. The codes provide a mechanism to identify and pay for services by care team members who have well-defined roles and relationships to one another, including services considered “incident-to” those provided by the primary billing practitioner. Accordingly, they provide the practice with the flexibility of paying for personnel (e.g., care coordinators) who are not providing billable services. There are caveats worth noting:

- There are important compliance requirements (adherence to evidence-based components of care)
- Not all Medicaid organizations nor commercial payers recognize (i.e., pay for) these codes
- The level of reimbursement varies and can be inadequate to cover the intended costs
- Because reimbursement for the codes is intended to cover operating, not “start-up” costs, practices within large systems (with more capital) generally have an advantage in funding these. The market solutions have proposed ways in which to overcome this hurdle.
- Since these are “primary care” codes that require practices to submit bills to cover the cost of care provided by other providers (e.g., behavioral health coordinator and consulting psychiatrist), many primary care practices are unfamiliar with or uncomfortable using this type of billing arrangement.

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Value-based payment options are an alternative to using the FFS-based collaborative care codes. Capitated payments to primary care providers (budgeted, value-based arrangements) in the context of a value-based contract can provide needed flexibility to reimburse different team members for a variety of functions. Value-based arrangements also support a population health orientation, which has the potential to motivate adoption of integrated care. Worth emphasizing: Though there are many advocates for value-based care more generally, there is not consensus that it is the preferred payment model for integrated behavioral care. Caveats play a role here too:

- Value-based arrangements require the development of measures that align with evidence-based care. These may be less prescriptive than the compliance requirements for collaborative care codes and, therefore, the care provided may not meet the evidence-based standards of the collaborative care model.
- There is always the concern that there are unintended consequences of value-based arrangements: by curbing unnecessary care, there is a risk of limiting the care that is foundational to a successful integrated behavioral health care program.

# Observations; Next Steps

Despite the incontrovertible evidence of its effectiveness and many playbooks providing guidance to practices on how to enhance adoption, we have a long way to go to realize the full potential of integrating BH into primary care.

While cultural, technical, and financial challenges are real, and taken together they pose real hurdles, motivated practices have managed to overcome these. What motivates one practice may not, however, provide sufficient inspiration to another. Beyond motivation, what is required for successful implementation<sup>1</sup> will differ depending upon practice size, staffing, patient and payor mix, and location.

In conclusion, there are two questions (no doubt with sub-parts) on which discussion could provide productive guidance and, taken together with recently published recommendations, can support more effective implementation of the integrated model of behavioral health care. We urge consideration of operational and policy changes together.

- I. What are the most effective incentives/ motivators for adoption of integrated behavioral health care?
  - What incentives work best for different types of primary care practices?
  - Are there incentives that function well for large health systems and health insurance plans? (These are the stakeholders that can scale the model more quickly than individual practices.)
  - Should mandates be considered (e.g., the requirement that certain primary care payments be conditioned on implementation of integrated care or accreditation standards, requiring integrated behavioral health care as a covered plan benefit)? Which mandates, if any?
  
- II. Even motivated practices require technical assistance to address creation of a patient registry, care team, billing and payment arrangements, and multiple work-flow issues. There is absolute consensus that while the CoCM and other forms of integrated behavioral health care are effective, implementation is complicated. Technical assistance can provide the necessary support that is required for implementation in practices that are already challenged. How can technical assistance be organized and scaled?
  - To be effective, technical assistance will need to be customized to account for the needs of a variety of primary care practices and to facilitate a practice's evaluation of its options. How can this best be accomplished? Can we identify what types of technical assistance need to be expanded to meet the most prevalent needs?
  - Identifying what technical assistance is required answers only half the relevant question. Can we identify how to pay for that technical assistance?

<sup>1</sup>Bipartisan Policy Center, "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration," Task Force Recommendations, March 2021.

NEHI and Chartis are reaching out to stakeholders to create a Collaborative interested in discussing the issues outlined above (I and II). We trust that Collaborative members will further refine these. Are you willing to participate? Do you know other stakeholders who would be willing to lend their experience and expertise to this ongoing discussion? Please email [WWarring@nehi-us.org](mailto:WWarring@nehi-us.org) or [mwenneker@chartis.com](mailto:mwenneker@chartis.com) to provide feedback and thoughts. We welcome the chance to engage across industry sectors to answer questions that seem to be up next in the effort to scale a critical solution to address the continued (and growing) unmet behavioral and mental health needs of the U.S. population.

Find additional resources shared by the panelists [here](#).

### About NEHI

NEHI is a national nonprofit, nonpartisan organization composed of stakeholders from across all key sectors of health and health care. Its mission is to advance innovations that improve health, enhance the quality of health care, and achieve greater value for the money spent.

NEHI consults with its broad membership, and conducts independent, objective research and convenings, to accelerate these innovations and bring about changes within health care and in public policy.



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