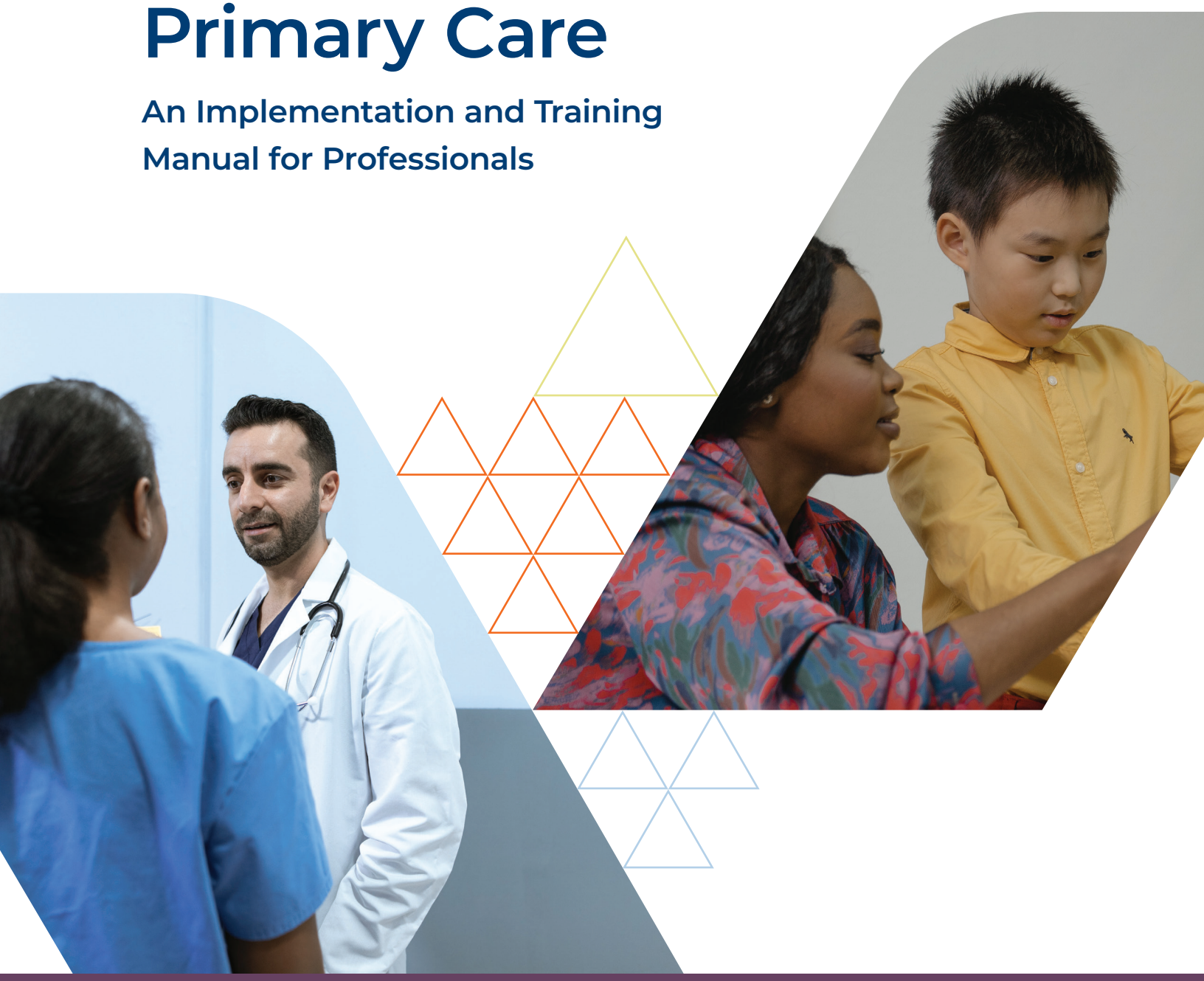
Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Pediatric Integrated Primary Care

An Implementation and Training Manual for Professionals



HRSA Health Workforce
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American Psychological Foundation, APF Cummings Psyche prize. $50,000, 2008.

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Contents

Introduction and Acknowledgments

Welcome! You are at the forefront of the movement to improve overall healthcare for children, adolescents, and families through the integration of behavioral health with primary medical care.

The field of integrated behavioral healthcare is exciting, fast-paced, and challenging, and it can be extremely rewarding for practitioners who are innovators and who are dedicated to improving the nation's healthcare delivery system. As a well-trained behavioral health professional in a primary care setting, you will offer behavioral services previously unavailable to children, adolescents, and families. You will be working with a variety of medical healthcare professionals in the creation of "medical homes" for patient-centered care. And no matter how long you are in an integrated care clinical practice, you will find daily opportunities to learn about new developments in healthcare, collaborative treatment approaches, and the challenging variety of physical and behavioral disorders seen in primary care. You will also experience feelings of appreciation from both medical providers and patients for providing behavioral services as part of their overall healthcare.

There are two major barriers to successful integration of behavioral health provision and primary care practices. First, unfortunately there have been a few failed attempts at integration due to hiring and/or placement of behavioral health providers who are "traditionally" trained and insufficiently prepared for practicing in a medical setting. According to Robinson and Reiter (2007), "Almost without exception, when a service fails, it is because of one fatal flaw: a failure to understand and appreciate primary care." This lack of understanding of how primary care medical practices function has produced dissatisfaction and rejection of the integrated care model by some medical providers and healthcare systems as well as dissatisfaction by the behavioral health provider (Fifield, 2010). Conversely, a second barrier relates to expectations of primary care providers and related staff who may be so desperate for behavioral health services for their clinic patients that they employ or contract with behavioral health providers who are not sufficiently prepared to work in primary care. In these cases, "any" behavioral healthcare is better than none, and practices may be thrilled to have access to a provider, despite services being far from ideal. Applied, practical training in integrated behavioral health is the answer to addressing both barriers!

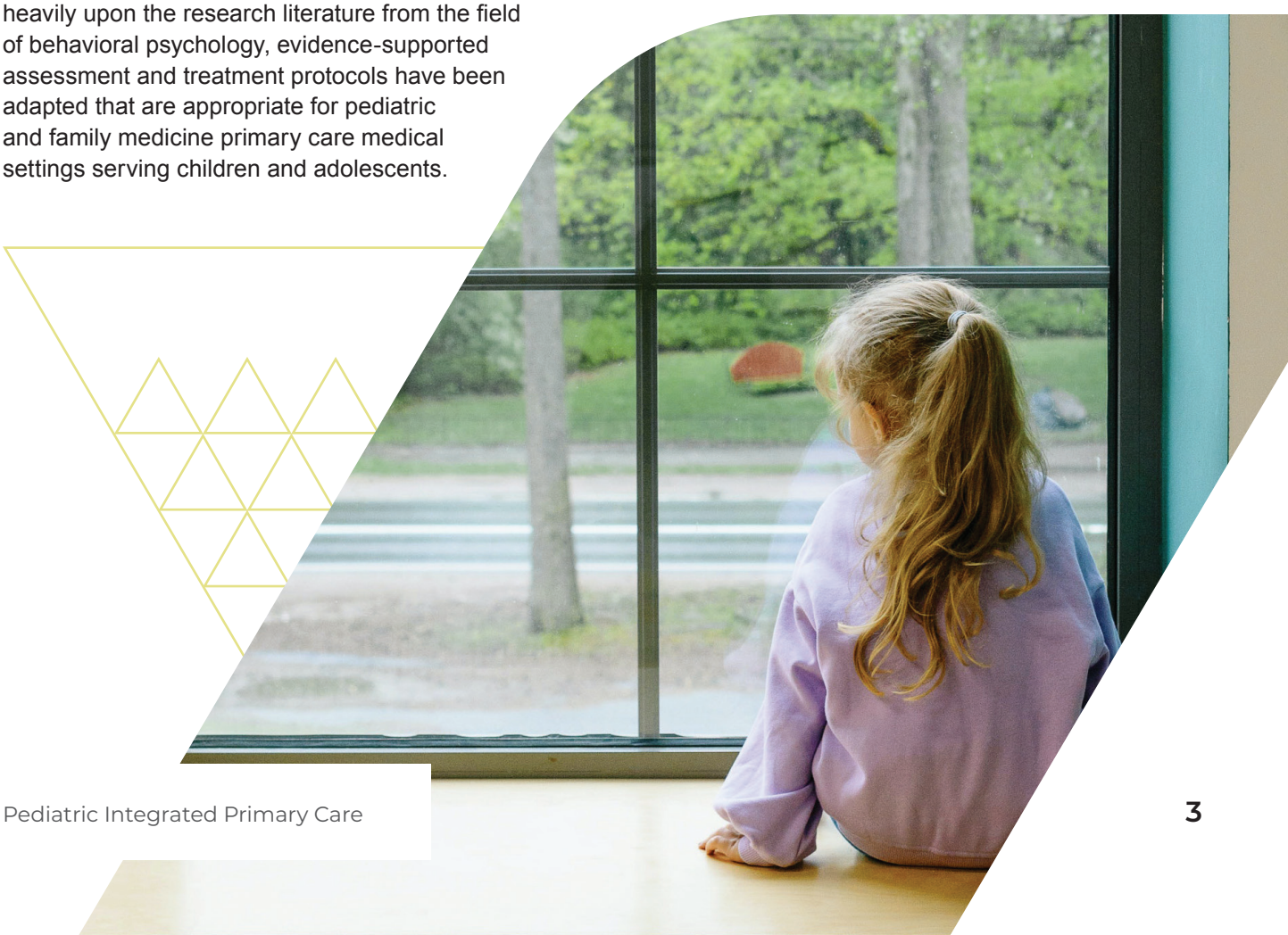
To become proficient and capable in behavioral health delivery within a primary care setting requires preparation, training, and some degree of clinical modeling, supervision, and feedback. Unfortunately, most graduate training programs in behavioral health are relatively "insulated," are not located within academic health science centers, and do not prepare students for practice in medical settings—particularly in primary care clinics. This trend is slowly changing through increases in interprofessional education between mental and physical health providers. There are some strong training programs in integrated behavioral health endorsed by the federal Substance Abuse and Mental Health Services Administration

(SAMHSA) and the Health Services Resources Administration (HRSA). Most of these programs, however, focus upon adult mental health conditions, and only a few have training to specifically address behavioral health in pediatric populations. This training manual is designed to address the need for improved preparation of integrated behavioral health providers for careers in addressing the healthcare needs, both physical and behavioral, of children, adolescents, and families.

As will be discussed in the following chapters, many types of practices have identified themselves as providing integrated care. The approach presented in this training manual, however, involves a pediatric version of the Primary Care Behavioral Health (PCBH) model. This approach involves placement of well-trained behavioral health providers "within" primary care medical practices. The pediatric PCBH model places an emphasis upon screening, prevention, early identification, and treatment of behavioral disorders through brief, evidence-supported interventions for children, adolescents, and families. Like a pediatrician or family medicine physician, the primary care behavioral health clinician becomes a resource for patients and their families throughout the periods of infancy, childhood, and adolescence. Relying heavily upon the research literature from the field of behavioral psychology, evidence-supported assessment and treatment protocols have been adapted that are appropriate for pediatric and family medicine primary care medical settings serving children and adolescents.

Utilizing this model, we have been successful in initiating, creating, and supporting over fifty integrated behavioral health clinics in pediatric and family medicine practices throughout our home state of Nebraska and in additional primary care practices throughout the country (in Pennsylvania, Michigan, North Carolina, Mississippi, Florida, and Iowa, and others).

In this manual, we discuss a multitude of topics ranging from methods of how to become a part of a primary medical practice, business options, contractual arrangements, relationship building, screening for behavior disorders, medical terminology, the electronic health record, common childhood diagnoses, service coding, billings, medications, and clinical productivity expectations. Primarily, however, we want to emphasize that the manual and accompanying modules provide training in evidence-supported assessment and treatment protocols for behavior disorders commonly seen in pediatric primary care practices. Although a behavioral health clinician can have excellent competencies in managing a practice, developing relationships with medical providers, and report writing skills, if the same clinician does not know how to address clinical

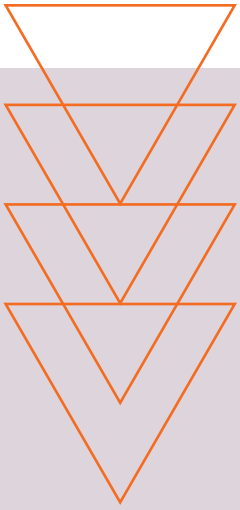


issues such as interventions for nocturnal enuresis, diagnosis of ADHD, or treatment of oppositional behavior disorder, the probabilities for establishing and maintaining a successful integrated care program are limited.

Therefore, we have created a series of online module courses to accompany this manual. These courses provide guidance for assessment and treatment of behavioral healthcare services across a wide variety of child-adolescent disorders. The courses are primarily intended to present evidence-supported protocols for clinicians in their integrated care practices that could supplement clinical training and supervision, such as would occur during an internship or clinical practicum experience. The modules also can be used, however, to provide advanced training in integrated primary care for licensed and experienced behavioral health providers who are new to integrated practice in medical settings or who are new to working with pediatric populations. Training module topics include assessment and behavioral treatments for obsessive compulsive disorder, adolescent depression, childhood anxiety, encopresis, enuresis, school behavior problems, and oppositional defiant disorders as well as preventive topics such as appropriate discipline for children and adolescents, developmental screening, working with schools, detecting substance abuse, and so on. It is our expectation that proficiency in the skills and competencies presented in this manual will enable a well-trained behavioral health provider to successfully address the vast majority of pediatric behavioral disorders presenting within the primary care setting.

Special Acknowledgments

The creation of this training manual is the culmination of years of development supported by awards and grants from the American Psychological Foundation, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Grants from HRSA's Bureaus of Health Professions and Behavioral Health Workforce programs have supported us in training more than two hundred doctoral level psychology interns over the past twenty years. Over half of these graduates have gone on to work in integrated care practices in Nebraska and across the country. Our internship and postdoctoral training program in pediatric integrated care is now being replicated at several university training programs in Pennsylvania, Michigan, and



Behavioral health integration achieves the **triple aim.**

Six Reasons Why Behavioral Health Should Be Part of the PCMH

1. **High prevalence** of behavioral health problems in primary care (needing long-term follow-up)
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction**

Tennessee. The development of this manual is built upon the conceptual frameworks of many of the pioneers in integrated behavioral health and from the results of twenty years of experience in training and dissemination in pediatric integrated primary care.

Because of our success in training and disseminating integrated behavioral healthcare, we were awarded funding from SAMHSA for the Mid-America Mental Health Technology Transfer Center (MHTTC). This grant provides training in behavioral health for a four-state area of the Midwest (Iowa, Nebraska, Kansas, Missouri). The MHTTC grant supports not only implementation of integrated behavioral healthcare but also provides education and technical assistance on other mental health topics, including school mental health, severe mental illness, and workforce development.

We are profoundly grateful to the American Psychological Foundation, the Health Resources and Services Administration (Bureau of Health Workforce), and the Substance Abuse and Mental Health Services Administration for past and continuing support from the following grants which have allowed us to implement integrated behavioral healthcare regionally in our state and nationally:

American Psychological Foundation

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No form of acknowledgment would be complete without recognizing the personnel who have been so dedicated to improving population access to behavioral health services, both in Nebraska and across the region and nation. Through their efforts, the development, training, evaluation, and dissemination of the Nebraska Pediatric Integrated Care Training program has flourished for two decades. The late Dr. Rachel Valleley was a mainstay for the program through her clinical training efforts both in rural and urban settings and for her outstanding capacities in data collection and program evaluation of our Nebraska Pediatric Integrated Care Training (NE-PICT) program. She participated with the integrated care training team for more than twenty years as an intern, post-doctoral fellow, faculty member, and model for countless students, interns, and medical residents. Dr. Holly Roberts has been a most valuable point person for the implementation and dissemination of our integrated care model. She has introduced, “sold,” and staffed our integrated care program to more than a dozen primary care clinics in Nebraska. A special thanks to Dr. Keith Allen, who for many years served as our internship director, recruiting excellent students from more than thirty states across

the nation as well as serving as an outstanding mentor for our program graduates. Special acknowledgment goes to Dr. Brandy Clarke, into whose very capable hands the leadership for our integrated care grant programs has been placed. Dr. Clarke's clinical, educational, and grant management background have made her an ideal choice for inheriting and directing primary care efforts far into the future. Finally, thanks to BHECN, the Behavioral Health Education Center of Nebraska, which has supported interdisciplinary efforts to improve the behavioral health workforce in Nebraska and has been a major supporter of our pediatric integrated care approach.

Other true clinical pioneers who have been invaluable to our mission of dissemination and replication of the pediatric integrated care training model include Dr. Cate Jones-Hazledine, a true advocate for rural behavioral health and founder of eight Western Nebraska Behavioral Health Centers; Dr. Nancy Foster, a Mississippi transplant who established the very successful Kearney IBH Pediatric Clinic twelve years ago and remains a valuable mentor for rural interns and practicum students; Drs. Shelley Hosterman and Tawnya Meadows, who introduced the pediatric integrated care model and expanded integrated care to twenty-plus sites in the Geisinger Health Systems (Pennsylvania); Dr. Blake Lancaster, who has replicated our training model in Michigan and has established five integrated primary care clinics through the University of Michigan Department of Pediatrics; Drs. Jenny Burt, Allison Grennan, and Tara Sjuts, who have supervised and trained numerous psychology interns, graduate students, and medical providers in our model of co-located pediatric IPC at UNMC; and finally, recognition to our two original integrated care psychologists, Dr. Tim Riley, now of the Lincoln Behavioral Pediatrics Clinic, and Dr. Jodi Polaha, currently teaching and disseminating integrated behavioral healthcare at the Quillen College of Medicine at East Tennessee State University.

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Munroe-Meyer Institute and Pediatrics

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Mid-America Mental Health Technology Transfer Center

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Chapter 1

Introduction to Integrated Primary Care

Welcome to the exciting world of collaboration between physical and behavioral health providers!

This training manual is designed to: a) serve as a supplement to graduate coursework in pediatric integrated primary care, b) serve as a blueprint for behavioral health professionals entering into the integration of behavioral health in primary medical practices, and c) with accompanying online courses, serve as an adjunctive resource for clinical training during internships, practicums, and/or postdoctoral training. The manual is also designed to provide expanded educational experiences for established behavioral health professionals who are "retooling" for positions in integrated primary care settings. Finally, the document provides a reference guide for integrated behavioral health professionals when addressing the challenges associated with administrative, clinical, or economic problems in integrated primary care. Accompanying online courses available via HealtheKnowledge provide information on evidence-supported protocols for assessment and treatment for many common behavioral health disorders presenting in pediatric primary care.

Only 6% of the American population see a Mental Health professional each year. By contrast, over 80% of the U.S. population sees a primary care practitioner each year (Robinson & Reiter, 2016).

Historical Perspective on Integrating Behavioral Health into Primary Care

A little over fifty years ago, the California-based Kaiser Permanante Health Maintenance Organization (HMO) found that 60 percent of physician visits were either by individuals who were having physical symptoms related to stress or whose physical condition had related emotional factors. Through offering mental health services, studies indicated a medical utilization reduction of 62 percent over five years. Following up on these findings, the National Institute of Mental Health (NIMH) funded several projects examining medical cost offset with results indicating reductions of overall healthcare costs of 30 percent to 65 percent. One significant finding that emerged from these studies was that the greater the collaboration between mental and medical primary care, the better the cost offset.

In 1981, The Health Care Financing Administration (HCFA) sponsored a seven-year prospective study in Hawaii to evaluate the impact of a collaborative behavioral health system among 36,000 Medicaid beneficiaries and 91,000 federal employees. The

results showed that brief, targeted interventions reduced or saved $350 per patient per year while typical psychotherapy services increased costs by $750 per year. Despite the reported success and cost savings of the integrated mental health model, acceptance and implementation of behavioral integration into primary care was slow to be adopted throughout the 1980s and 1990s.

Behavioral health integration gained support at the federal level when the Veterans Administration began to add primary care psychologists into its clinics to meet the increasing mental health demands of military veterans returning from war. More recently, federal support from the Health Resources and Services Administration (HRSA) has emphasized “primary care behavioral health” as a solution for its Federally Qualified Community Health Centers to address the overall health needs of Medicaid-insured and uninsured citizens.

Over the past twenty-plus years, there has been an increasing emphasis upon the interaction of physical and mental health as impacting overall patient well-being and functioning. Estimates indicate that approximately half of all pediatric primary care visits involve a behavioral health concern. Stress, anxiety, depression, and pain have all been identified as impacting adults’ physical health status. Adverse childhood experiences (ACEs) have been found to impact health, behavioral, and learning problems in children and increased health disorders, including heart disease, in adults. Conversely, many physical conditions, such as diabetes, epilepsy, COPD, and cancer can have a significant impact on patients’ mental health, often leading to depression and feelings of hopelessness.

Despite our increasing knowledge about the interaction of physical and behavioral health, there has been a tendency to treat these two areas of healthcare as independent. For example, most insurers, until recently, have separated physical health reimbursements from behavioral health payments, thus creating an artificial dichotomy related to overall healthcare delivery. This has led to significant difficulties in getting access to behavioral healthcare for the estimated 21 percent of individuals (SAMHSA, 2021) who currently have diagnosable mental health disorders. Estimates indicate that 67 percent of individuals with a behavioral health disorder do not get appropriate treatment. Of those referred for behavioral health services by primary care medical providers, 30 percent to 50 percent of these referrals do not make their first appointment. And as many as

50 percent of patients with depression go undetected in the primary healthcare delivery system.

Parents of children and adolescents with behavioral or mental health concerns often do not seek out services from a behavioral health professional. Studies indicate that most patients first contact their primary care physician, even though the majority of these primary care providers report feeling unprepared or uncomfortable in managing behavioral difficulties.

Estimates indicate that 67 percent of individuals with a behavioral health disorder do not get appropriate treatment (Kessler et al., 2005).

In turn, primary care providers frequently make outside referrals for their patients' behavioral healthcare needs although two-thirds report not being able to gain access to behavioral healthcare for their patients due to shortages of providers, insurance barriers, and lack of health insurance coverage. Consequently, physicians have become de facto behavioral health providers (Kessler & Stafford, 2008), particularly in underserved rural and inner-city urban areas.

Integration of behavioral health providers into medical primary care healthcare systems provides a solution to this problem. In serving adults with behavior disorders in primary care, there are several excellent training programs (University of Massachusetts, Mountain View Consulting Group, University of Washington, Cherokee Health Systems, etc.) that prepare behavioral health professionals for entry into primary care practices. Most notably, however, these training programs are primarily designed for general internal medicine and family medicine primary care practices serving adults. Fewer training programs have a focus on behavioral health integration into clinics serving children. While there are many iterations of "integrated behavioral healthcare," this training manual focuses on a model that prepares behavioral health professionals to diagnose and treat children, adolescents, and families within primary care pediatric and family medicine practices.

Over the past fifteen years, there has been an expansion of integrated behavioral health training programs due to increased attention to social problems (e.g., school shootings, gun violence, etc.). Grant funding from the Health Resources Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) has markedly increased training and workforce development efforts in integrated behavioral health. Many grant programs from these agencies are associated with university training programs providing internship stipends in integrated primary care for trainees in psychology, social work, counseling, psychiatric nursing, and marriage and family therapy, as well as fellowship support for postdoctoral psychologists. Again, the majority of these programs have focused on behavioral health services for adults. There remains a major need for training of behavioral health clinicians to work in primary care settings for children and adolescents.

Additionally, although integrated behavioral health training programs have primarily been for graduate programs in the behavioral health professions, recent funding has been expanded to include behavioral health training for primary care physicians, nurse practitioners, and physician assistants to better identify patients with behavioral health disorders and to collaborate with behavioral clinicians in primary care settings or through telehealth consultation. Despite these efforts, there remain major deficits in preparing both behavioral health clinicians and medical personnel for integrated care collaboration. We briefly discuss some of the more prevalent models of integrated behavioral health in the following sections of this chapter.

What is Integrated Care?

One commonly accepted definition of "integrated care" is that integrated behavioral health (IBH) is:

> *Care resulting from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization (C.J. Peek, National Integration Academy Council, 2013, p.21).*

Models of Integrated Care

There are many approaches to integrating behavioral services into physical healthcare. These variations involve:

1. Psychiatric telehealth consultation
2. Behavioral clinicians assigned to specialty medical clinics
3. Cooperative agreements between behavioral and referring medical clinics
4. Provision of behavioral healthcare within the primary care medical clinic

The following sections of this chapter present and discuss some of the integrated care approaches currently in use. The remainder of this training manual, however, concentrates upon a version of the Primary Care Behavioral Health (PCBH) model that prepares behavioral health professionals to work in collaboration with physicians and related providers within the primary care setting. This training manual provides recommendations, practical guidelines, and procedures for establishing a pediatric co-located or PCBH practice. The manual is designed to be accompanied by a series of online modules that address clinical applications of evidence-supported treatment interventions for common child-adolescent behavioral issues presenting in primary care practice. The training modules include protocols for assessment and focused treatment of conditions, including ADHD, anxiety, OCD, depression, oppositional behavior, enuresis, encopresis, substance abuse, etc. Also included are guidelines for child and adolescent discipline, working with the special education system, and developmental assessment.

Specialty Behavioral Health Care Model

Hospitals and physician groups have "medical specialty" clinics staffed by physicians who have completed advanced fellowship training in specific areas of medicine. Many of these specialty clinics have incorporated behavioral health into their service delivery systems. For example, psychologists and social workers are often employed to provide behavioral health services in specialty healthcare practices such as gastrointestinal, cardiac, neurologic, genetic, and pulmonary clinics, among others. In these specialty clinics, behavioral health providers collaborate with physicians and develop highly specialized skills in dealing with populations of patients who have specific physical health disorders, providing important behavioral assessment and treatment to patients as part of the healthcare team. The goal in these clinics is to address the medical issues related to diseases of a specific physical condition or bodily system, including related behavioral

Integrated care is "Care resulting from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population." (C.J. Peek, National Integration Academy Council, 2013, p.21).

issues. Behavioral providers in these clinics generally limit services to a single patient population. For example, some psychologists employed in neurology clinics only see patients referred for neurological disorders.

Coordinated Care Community Referral Model

Another form of integrated behavioral healthcare involves the creation of a behavioral health referral source (or network of sources) between physicians (specialty care or primary care) and behavioral health providers from the surrounding community. In this model, patients are provided with referrals to mental health agencies or private behavioral health providers who have agreed to see referred patients. Patients may be given a number of behavioral health provider options, largely based upon the match of patient insurance coverage and the "insurance panels" in which behavioral health providers participate. As noted above, however, there is a large proportion of patients (30 percent to 50 percent) who do not make their first appointment. This can be due to lengthy delays in scheduling, transportation problems, limited after-working hours' appointments, shortages of providers, stigma, etc. Such arrangements, unfortunately, also provide limited possibilities for coordinating care between physical and behavioral health providers. Additionally, while it is assumed that community behavioral health providers will communicate findings and treatment progress with referring primary care providers, a major complaint about this model has been lack of reciprocal communication, frequently due to perceived concerns over confidentiality and HIPPA.

Collaborative Care — AIMS Model (CoCM)

The Collaborative Care, or AIMS, model of integrated behavioral health in primary care has been shown to have a positive impact on adult mental health disorders, particularly depression in adults (Unutzer et al., 2013). In this approach, behavioral health services are provided by primary care physicians with available telephone or telehealth consultation from collaborating psychiatrists. Within the primary care setting, a "care manager" or "depression manager" (usually a nurse or social worker) is designated to screen patients, take referrals from primary care providers, and create registries of patients for periodic follow-up. Care managers assess whether patients need behavioral health consultation from a collaborating psychiatrist and may also provide some behavioral interventions. Care managers arrange and schedule consultations between the patient's primary care provider and consulting psychiatrist, usually introducing or revising medication management as the main course of treatment. Evidence for this approach has largely come from studies of adult populations and has focused on treatment of depression and anxiety with positive results from repeated clinical trials. Difficulties with this model come from shortages of available consulting psychiatric providers and the additional time required of the primary care physician above and beyond direct care medical services. Also, in this model, emphasis is primarily upon psychotropic medication management.

Primary Care Behavioral Health Model (PCBH)

The Primary Care Behavioral Health approach to integrated care makes the behavioral health provider part of the organizational structure of the primary care practice (Reiter, Dobmeyer & Hunter, 2018). In a PCBH model, a licensed behavioral health provider is physically placed within the primary care space. Emphasis is placed on screening, prevention, and brief treatment of common behavior problems presenting in family medicine, general internal medicine, or pediatrics. Patients are seen within the clinic in exam rooms or spaces adjacent to primary care physicians. Pathways are developed to manage referrals and coordinate patient assessment, diagnosis, and treatment. Shared support systems such as scheduling, electronic health records, billing, and collections are available. Patients are referred by their primary care physician or can be scheduled through "warm hand-offs" so that patients with greatest needs can be triaged for more immediate care. Short-term therapies are the norm in the PCBH model (i.e., three to five sessions are typical). The primary care behavioral health clinician becomes an ongoing resource for patients and families, analogous to the role of their primary care physician, being available throughout the lifespan (or through the end of adolescence in pediatric

Integrated behavioral healthcare provision for children and adolescents focuses on screening, prevention, and early intervention.

primary care). Finally, community referral sources are established by the primary care behavioral health practitioner for patients requiring placement or longer-term treatment. Implementation of the PCBH model of integrated care can be challenging due to a lack of programs that provide training in integrated behavioral health, difficulties in finding adequately trained clinical supervisors, and concerns of primary care practices that integrated care will require significant clinic resources.

Pediatric vs. Adult Primary Care Behavioral Integration

Although there are many similarities in the provision of primary care behavioral health for adults and children, there are significant differences that warrant the development of training specific to pediatric populations. Behavioral health services for adults typically focus upon already established behavioral health disorders. By contrast, pediatric integrated care has a major focus on prevention, as 50 percent to 75 percent of adult mental health disorders have origins in childhood, before the age of fourteen (Kessler et al., 2005, 2007). Integrated behavioral healthcare provision for children and adolescents focuses on screening, prevention, and early intervention. This approach can alter the development of more severe mental health disorders, lead to better quality of life and family functioning, and also produce improved physical health outcomes. The following are some of the major areas of delineation between adult and child-adolescent behavioral health applications.

First, there are significant differences in the types of behavioral health disorders encountered in primary care between adult and child populations. Behavioral health disorders among adults tend to focus upon "internalizing problems," with anxiety, pain, and depression being most common. By contrast, a good portion of behavioral health disorders exhibited by children and adolescents are "externalizing behaviors," such as oppositional defiant disorder (ODD), attention deficit hyperactivity disorder (ADHD), and conduct disorder (CD). Other child-adolescent disorders often found in pediatric, as opposed to adult, populations include elimination disorders (enuresis and encopresis), excessive tantrums, oppositional behavior, school refusal, and responses to trauma such as encountered in abuse and neglect, bullying, etc. Internalizing disorders in adolescents often have their origin in early childhood leading to anxiety, obsessive-compulsive disorder, depression, and habit disorders.

Second, the "patient" in integrated primary care is not only the child or adolescent but also the parents and, frequently, the entire family. When managing pediatric behavioral health concerns, a well-trained clinician will spend the majority of treatment sessions working with parents or caregivers. As children age, more direct service time is spent with adolescents as they develop the capacity to understand and respond to cognitive-based treatments. For younger children, however, parent involvement is crucial as parents are generally the instigators for seeking behavioral health services. Addressing their parental concerns largely determines success or failure of behavioral health interventions.

Third, behavior change in children and adolescents nearly always involves getting parents to alter their managing of and responses to their children's behavioral difficulties. In other words, initiating and maintaining changes in child behavior generally first requires changes in parent behavior. Clinicians working with pediatric populations need to not only have expertise in child-adolescent behavioral interventions but also in motivating adults to alter their strategies in dealing with their children.

Fourth, treatment of children and adolescents frequently requires intervention in conflicts between parents. Often found in pediatric behavioral health practices are major disagreements on discipline, with one parent being accused of being "too easy" on the child while the other parent is viewed as being "too harsh" in handling the child's challenging behavioral issues. These differences in parenting style often lead to blaming and disruption within the family constellation (and sometimes require a referral to a marriage and family therapist).

Fifth, many behavioral health services for adults involve cognitive strategies and written prescriptive interventions for use by adult patients. Children and many adolescents are not yet emotionally and mentally developed to understand and respond to such cognitive treatment applications. Instead, working with parents often involves getting parents to apply behavioral protocols through psychoeducation, provision of therapist modeling, feedback, and "homework assignments" between sessions.

Finally, in adult behavioral health treatment, therapists have little or no control over environmental influences impacting their patients' mental status. Much of behavioral health therapy for adults is focused upon adjusting one's adaptation to the environment over which one has little control. By contrast, parents generally have control over their children's environments, including both positive and negative consequences for behavior. Adjusting these environmental factors to be more positive and less punitive is a major component of treatment for behavior disorders in children and adolescents. Behavioral health treatment involves parental instruction, modeling, shaping, and reinforcement of pro-social behaviors as well as skill development in managing child-adolescent behavioral issues. Treatment also frequently involves environmental changes and interventions in a child's school, daycare, and extended family (e.g., grandparents, nannies, caregivers, etc).

Advantages of Integrating Behavioral Health into Primary Care

Some features of integrated primary care (IPC) may not be initially obvious. As one progresses in the integration process, there can be found distinct advantages of this approach for patients, healthcare providers (physicians, NPs and PAs), and behavioral clinicians.

Behavior change in children and adolescents nearly always involves getting parents to alter their managing of and responses to their children's behavioral difficulties.

Benefits of IPC for Patients:

- Comfort in receiving behavioral healthcare in a trusted health provider's office
- Anonymity in accessing behavioral health services
- Reduced stigmatization
- Coordinated physical and behavioral healthcare
- Decreases in unnecessary medical utilization
- Decreases in emergency department visits
- Reduced costs for travel and missed school/ work time
- Availability of ongoing behavioral health services throughout childhood and adolescence

Benefits of IPC for Healthcare Providers:

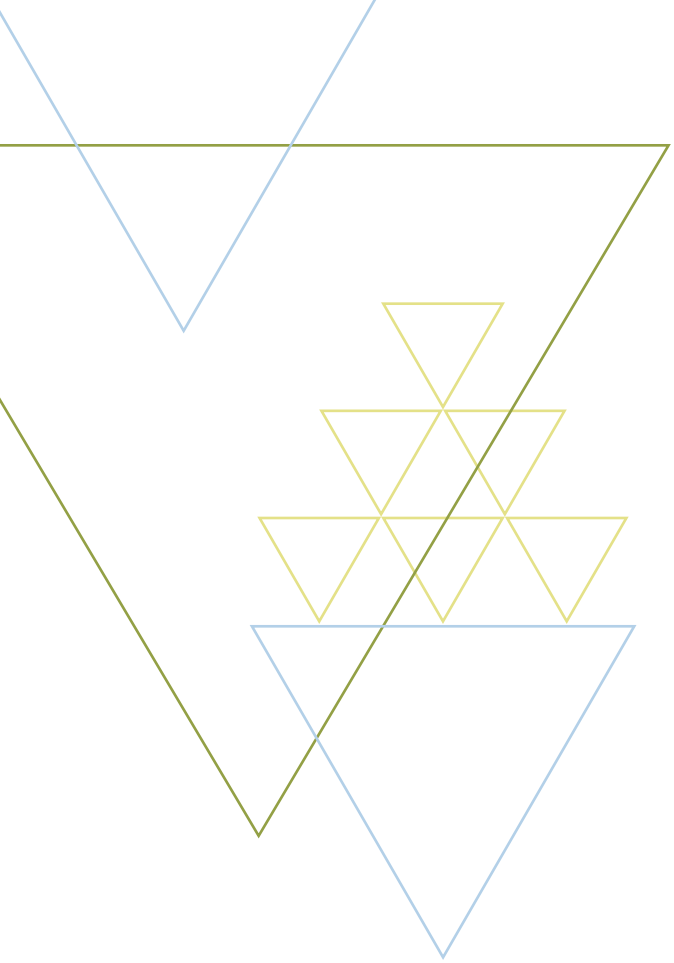
- Availability of a “ready” behavioral health referral source
- Improved capacity for detection of behavioral health disorders
- Capacity to triage patients who are in greatest need
- Reduction in primary care providers’ time spent managing behavioral health crises
- Coordination of physical and behavioral health
- Enhanced communication and treatment planning with behavioral health providers
- More time to manage physical health of patients
- Increased numbers of patients treated and relative value units (RVUs) (leading to increased income)
- Increased confidence that patients will schedule and attend behavioral health sessions

Benefits of IPC for Behavioral Health Clinicians:

- Consistent referral stream of patients from primary care medical providers
- Coordination of medication and behavioral treatments
- Reduced/shared practice overhead
- Physician availability for consultations regarding medical conditions affecting behavior
- Enhanced communication with primary care providers
- Community acceptance as part of the medical clinic treatment team
- Reduction in stigma for patients being seen in primary care vs versus behavioral health clinics

Barriers to Integrating Behavioral Health into Primary Care

We have discussed the history of integrated behavioral health, models of integrated care, differences between adult and pediatric behavioral health services, and advantages of integrated primary care for patients, medical providers, and behavioral clinicians. With all of the positive aspects of integrating physical and behavioral health, why has the movement toward integration taken so much time to develop? If this concept is so positive, what has been the reluctance to integrate behavioral health provision into primary care practices? And, more specifically, what barriers have impeded the adoption of the IBH model into pediatric practice? These are questions typically encountered as one strives to integrate behavioral health into primary care.



Barrier One: Economics of Primary Care

Although they see the largest number of patients, the widest variety of behavioral and physical conditions, and make the greatest number of referrals to specialty care within a healthcare system, primary care providers are generally at the lower end of the pay scale within the field of medicine. Any new potential costs to the primary care practice can be perceived as threats to income. As noted in Chapter 3, primary care managers have three major areas of economic concern regarding the integration of behavioral health into their practices. These involve: 1) potential costs to the clinic, 2) space needs, and 3) support staff requirements.

Until recently, with the advent of Health and Behavior billing codes, primary care providers have not been able to bill for mental/behavioral health service provisions (and in many states, Medicaid programs and insurers have still not approved use of these codes). Behavioral health, within the healthcare insurance industry, has traditionally been "carved out" of health insurance plans, and a separate system has been established for coding and billing for behavioral health services. As primary medical care practitioners are not licensed to provide mental healthcare, they have not been able to bill for mental/behavioral services, even though behavioral issues are brought up by patients in pediatrics during 60 percent of visits. Primary care practitioners are, understandably, concerned about potential drains on the revenues of the practice, losing valuable clinic space, and/or putting additional demands on their already busy support staff.

Similarly, start-up costs for behavioral health clinicians can be prohibitive. If hired by a practice, there may be months before revenues from insurers or Medicaid can offset salaries and benefits for the new behavioral health staff addition(s). If working independently or through a contractual arrangement, approvals for billing are reliant upon licensure, paneling with insurers, and certification of the primary care billing site. Overall, a conservative estimate is that income to the clinician or the primary care practice will take approximately four to six months for the behavioral health practitioner's revenue generation to begin to "break even" with associated salaries and costs. At the same time, it should be noted that there will be cost benefit offsets for the primary care practices through increases in practitioners' time, availability, and revenue generation. Studies have indicated that primary care providers can be more productive when a behavioral health provider is incorporated into the practice. One study demonstrated that a primary care practice of five practitioners billed $1,142 more on days when a behavioral health clinician was present

Working with parents often involves getting parents to apply behavioral protocols through psychoeducation, provision of therapist modeling, feedback, and "homework assignments" between sessions.

in the clinic versus days without behavioral heath support (Gouge et al., 2016) These cost-offset benefits to the medical practice should be considered when justifying initial behavioral health costs that may be encountered during the implementation of IBH in a primary care clinic.

Barrier Two: Shortages of Behavioral Health Providers

Even when there is a request from primary care practitioners to add a behavioral health clinician to their clinic, there is a significant shortage of licensed behavioral health providers in two-thirds of the country, particularly in rural and inner-city areas (HRSA, 2020). By way of example, 87 percent of counties in Iowa, 93 percent of counties in Kansas, and 95 percent of counties in Nebraska are considered Mental Health Professions Shortage Areas (MHPSAs) as defined by the federal Health Resources Services Administration. Thirty-two of Nebraska's ninety-three counties have no licensed behavioral health provider of any type, and only eleven counties have a practicing psychiatrist. Appointments to see a psychologist, clinical social worker, counselor, MFT, or psychiatrist can take weeks or even months. In response, some primary care providers have taken the position that they avoid screening for behavioral health disorders as they do not have available referral resources and feel they could be liable if a behavioral concern is expressed but goes unaddressed. Consequently, when referrals for serious behavioral health concerns are made, patients are very often sent to the nearest hospital emergency department which, in many rural areas, has become the local "psychiatric unit," frequently costing thousands of dollars and sometimes requiring days until a psychiatric evaluation appointment can be obtained or the patient can be transferred.

Barrier Three: Lack of Training Programs in Integrated Care

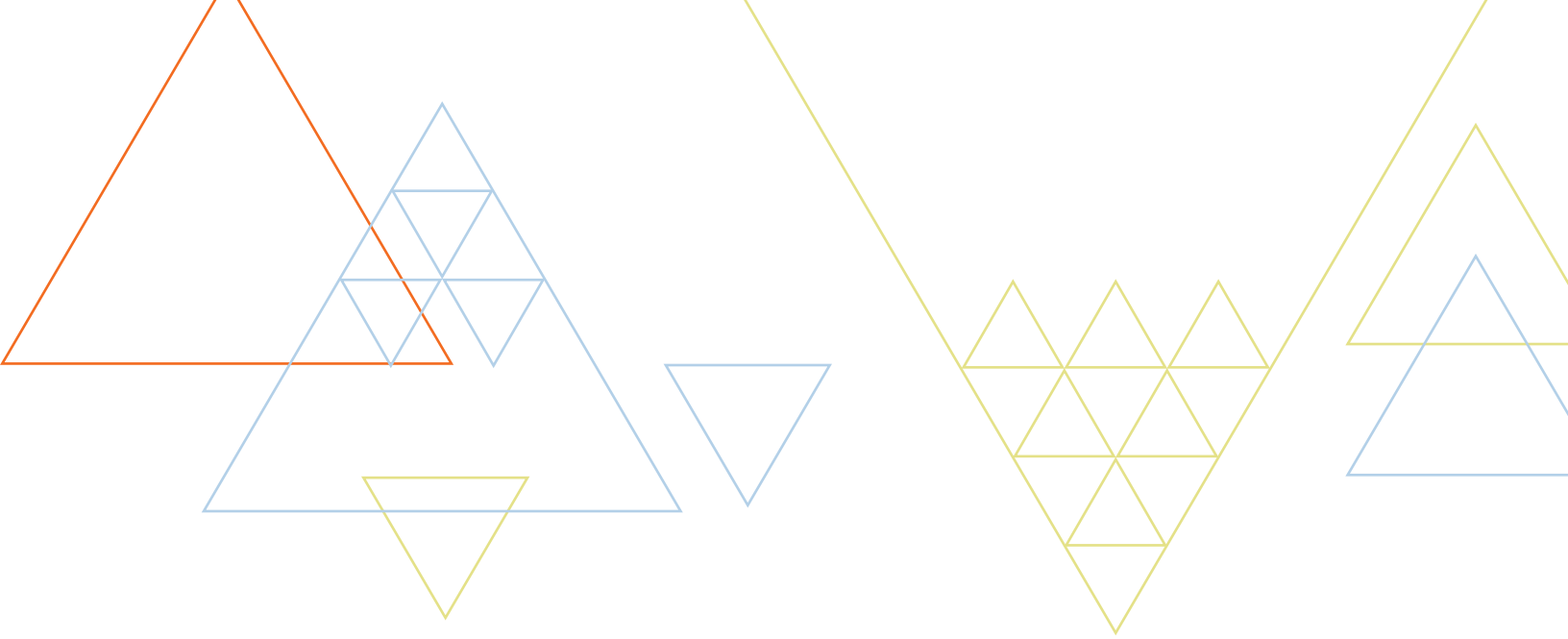
Applied graduate educational programs in the behavioral health professions are generally located in Colleges of Arts and Sciences, Education, or Social Sciences. The vast majority of behavioral health training programs have few, if any, interprofessional educational classes or applied clinical experiences in common with students from Colleges of Medicine, Nursing, or Allied Health.

Many traditional training programs in behavioral health prepare their graduates for service provision in mental health agencies or in private practices. Behavioral parent training treatments range between ten to sixteen weekly sessions (Eyberg et al., 2008) and result in attrition rates up to 50 percent (Danko, Garbacz & Budd, 2016), and some patients may even be seen for years. Many patients seen in traditional behavioral practices have serious emotional or behavioral disorders, and the focus of care is on coping, not on prevention or early intervention (Williams, 2020). Consequently, there are few behavioral health graduates who are being adequately prepared to work collaboratively within integrated pediatric primary care settings (e.g., Miller et al., 2020).

Similarly, physicians, nurse practitioners, and physician assistants have very limited formal training in behavioral health. During their years of residency or practicum training, primary care physicians

There are few behavioral health graduates who are being adequately prepared to work collaboratively within integrated pediatric primary care settings (e.g., Miller et al., 2020).

generally report that their training in mental health was not adequate (e.g., Nasir, Watanabe-Galloway & Coffey, 2016). Depending upon the composition of the patient population seen in their training clinics, medical students and residents may or may not obtain practical experiences in working with patients with behavior disorders.



One major advantage of employment or contracting with a medical practice for integrated behavioral healthcare is that many costs can be minimized, reduced, and/or shared with the primary care clinic.

Barrier Four: Lack of Training in Business Applications

Most graduate training programs in behavioral health do not provide their students with information about the "business" of conducting a behavioral health service program. Graduates are not trained to consider the costs of entering into applied practice. For graduates entering into independent practice, information on contracting, insurance paneling, site certification, professional liability insurance, the Stark Act, job descriptions, accounting, etc., is not typically taught during graduate training. In addition, typical "practice costs" are not included in training, such as the purchase of electronic health record software, billing programs, collection services, rental space, receptionist costs, test materials, office furniture, telecommunication equipment and services, etc. One major advantage of employment or contracting with a medical practice for integrated behavioral healthcare is that many costs can be minimized, reduced, and/or shared with the primary care clinic.

Barrier Five: Need for Behavioral Health Colleagues

One of the significant disadvantages, specifically for behavioral health providers entering into rural integrated care practice, is a potential lack of collegiality with other behavioral health providers. Lack of access to other behavioral health clinicians can be frustrating when seeking consultation on a particular case, sharing problems that may arise in the primary care practice, or simply needing a social support network. This problem is generally minimized in large urban healthcare systems in which there are multiple behavioral health providers that regularly interact with one another. In such organizations, there is usually a common interest group or department providing coordination, continuing education, and support for integrated behavioral health clinicians. In private, stand-alone clinics, such as typically found in rural settings, this can be a more significant problem, and the behavioral health clinician may need to seek out relationships with other practitioners and/or behavioral health academic training programs for collegial contact and supports.

Conclusion

The prevalence of mental and behavioral health concerns in children as well as the number of cases that go untreated makes integrated primary care an ideal strategy for meeting the behavioral health needs of children and adolescents. There are several ways to define and describe integrated primary care. However, common to all models is placing the primary care provider as the de facto mental health provider to screen and refer patients for behavioral health needs. There are a number of benefits and challenges associated with integrating behavioral health in primary care. The remaining chapters in this manual will focus on how to navigate components of integrated primary care and establish an integrated primary care clinical service model while building a workforce to manage the behavioral health needs of children and families.

Recommended Resources for Further Reading

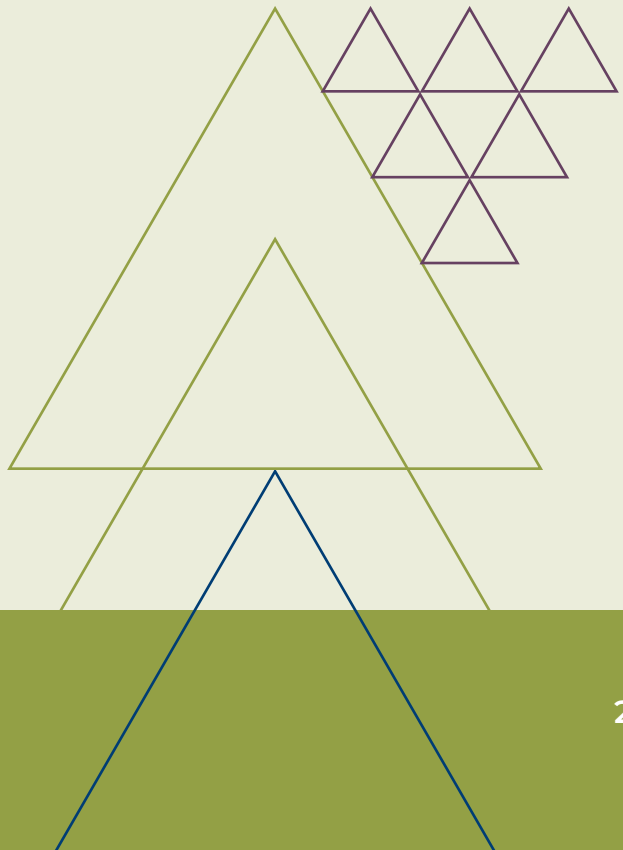
Gouge, N., Polaha, J., Rogers, R., & Harden, A. (2016). Integrating Behavioral Health into Pediatric Primary Care: Implications for Provider Time and Cost. *Southern Med Journal*, *109*(12), 774–778. doi: 10.14423/SMJ.0000000000000564

Asarnow, J. R., Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA pediatrics*, *169*(10), 929–937. doi: 10.1001/jamapediatrics.2015.1141

Kolko, D. J., & Perrin, E. (2014). The integration of behavioral health interventions in children's health care: services, science, and suggestions. *Journal of Clinical Child & Adolescent Psychology*, *43*(2), 216–228. doi: 10.1080/15374416.2013.862804

Tips and Take-Home Points

- There is a notable history of attempts to integrate behavioral health into primary care dating back over 50+ years, but integrated care has been slow to be adopted until recently.
- Medical cost offset studies have demonstrated significant savings in medical costs through integration of behavioral health into medical clinics.
- There is a reciprocal relationship between physical and behavioral health disorders. Many physical illnesses have co-morbid behavioral concerns. Conversely, many behavioral disorders have a deleterious impact on physical health.
- Over the past 20 years there has been increased attention to, and funding for, the integration of behavioral health services into primary care (from HRSA, SAMHSA, etc).
- There are significant differences in behavioral health service provision for adults vs. for children and adolescents.
- There are few graduate training programs for integrated behavioral health. Those that exist primarily focus upon services for adults. Only a few programs are designed to train behavioral health providers to work with children, adolescents, and families.
- Major advantages exist for patients, medical providers, and behavioral health clinicians through the application of integration of behavioral health into primary care.
- Barriers to integrated behavioral health include perceived costs to the primary care practice, a shortage of trained behavioral health providers, few behavioral health training programs, and lack of training in the business of primary care.



Chapter 2

Terminology and Definitions

This chapter is written for behavioral health clinicians new to integrated primary care (IPC).

For those individuals who have already had experience in working in the medical field, much of this chapter will be familiar. In this section we focus on administrative terminology that is common and necessary for the behavioral health clinician. Medical terminology and commonly used medical terms are covered in another chapter later in this manual. Throughout this document, abbreviations may be used for many of the terms presented below. For ready reference, however, we make this chapter available to clinicians. (Note: The terms *mental health* and *behavioral health* are used interchangeably. The frequent use of *physicians* is intended to include all primary care providers, including nurse practitioners and physician assistants. Similarly, the terms *integrated primary care* and *integrated behavioral health* are identical in usage for the purposes of this manual.)

Foundational Concepts

Primary Care (PC): Defined as the practice of general medicine. As opposed to "specialty" medical practice, primary care covers the fields of General Pediatrics, Family Medicine, and General Internal Medicine. Primary care is the medical provision site in the community for most individuals and families and is typically the focal point for addressing the multitude of healthcare issues for patients, from vaccinations and treating the common cold to acute injuries and routine management of chronic care for conditions such as diabetes or epilepsy.

Integrated Primary Care (IPC): This term is used to describe primary care practices in which behavioral care occurs in primary care at various levels (Heath et al., 2013) through: a) coordination with local agencies (Levels 1–2), b) co-location within primary care practices (Levels 3–4), or c) through "full" integration (Levels 5–6). There are varying levels of collaboration between physical and behavioral health providers in these scenarios. In this manual we emphasize a model of integrated care that involves placement of a behavioral health provider within the primary care medical practice with some degree of full integration (Levels 4–5).

Levels of Integrated Care

Coordinated Care: At the "coordinated" level of integrated care, physical and behavioral services are located at different sites within or near the community. Referrals are mutually accepted from one provider to another through informal, and sometimes contractual, agreements. Information is exchanged on a routine basis when patients are in treatment in both settings and there is an attempt to bridge the differences of culture between a primary care medical service setting and a mental health service setting. Possibilities for integrating care across settings are difficult and time consuming as there are usually differences in approaches to confidentiality, phone calls, interruptions, and interventions for behavioral problems (Blount, 2003).

Co-Located Care: At this level of integration, behavioral and medical health services are located in the same practice site. Reception areas are common,

and some support staff may be shared. Referrals for behavioral healthcare come from physicians, other primary care clinic staff, or from other community agencies, schools, or physicians. There are usually two sets of electronic health records, one for medical and one for behavioral care. Behavioral health clinicians are viewed as "specialty providers" who are available to the practice for referrals but are not really part of the practice's healthcare team. Co-location improves communication between behavioral health and medical providers but does not involve regular case collaboration, and there are usually two separate treatment plans—one for physical and the other for behavioral intervention. Collaboration is more feasible than when care is provided in two separate clinic settings. Finally, in co-located care, "medical providers can be better attuned to behavioral health providers can provide. Behavioral health providers become acculturated to the language and treatment assumptions of primary care" (Blount, 2003, p.123), but the two systems still remain separate.

(Fully) Integrated Care: The highest level of integrated primary care involves full coordination of services to patients, encompassing medical and behavioral aspects of care. A hallmark of this level of care is the presence of a common treatment plan and an electronic health record. A second recognizable factor in fully integrated care is that services are delivered by a "team" of physical and behavioral practitioners. Communication is frequent and ongoing. Patients are commonly seen by a combination of a physician and behavioral health clinician. Referrals to behavioral health providers can be for presenting behavioral problems or for medical conditions that have related behavioral issues. Similarly, referrals to physicians are common for introducing medication management or for reviews of medications that may be having adverse side effects.

Business Terms Commonly Used in Primary Care Practices

Patient Centered Medical Home (PCMH): This term is used to describe medical practice sites that meet qualifications for being a "Medical Home" with a focus on coordination of individual patient healthcare needs. The Medical Home is generally located within a primary care setting and coordinates all healthcare services, including specialty care referrals. To become a PCMH, a clinic must have six characteristics: Patient-Centered Appointment Access, Practice Team (Team-Based Care), Use Data for Population Management, Care Planning and Self-Care Support, Referral Tracking and Follow-up, and Implement Continuous Quality Improvement (Hahn, et al., 2014).

Integrated primary care meets many of these guidelines through: a) a whole person orientation—integrating mind *and* body healthcare, b) personalized care across acute and chronic problems, including prevention with focus on the physical, social, environmental, emotional, behavioral and cognitive aspects of healthcare, c) enhanced access to the range of physical and mental health needs for systems implementing collaborative care for mental health and physical health, and d) payment for added value including evidence-based screening, assessment, and intervention for mental/behavioral health, substance use, and health behavior change.

Integrated primary care also results in achieving the quadruple aim through training mental and medical healthcare providers to screen, diagnose, and treat common medical and behavioral conditions and to refer their patients with specialty needs to clinics such as orthopedics, surgery, neurology, pulmonology, ophthalmology, psychiatry, etc.

Insurance Panel: This term refers to a network of healthcare providers who are approved by a health insurance company to provide services to that company's insured members. In order to be reimbursed for services provided, healthcare professionals must be "paneled" by the insurer. This process generally involves submission to and review of licensure and credentials by the insurance company. In some cases, insurance panels are full and may not accept new practitioners. In those unusual cases where a patient has health insurance for which a healthcare provider is not paneled, a request for an out-of-network exemption can be made to the insurer.

Electronic Health Record (EHR; aka Electronic Medical Record): Replacing the practice of medical files on paper, the electronic health record is designed to maintain patient health information on computer files that can be accessed by any of a patient's healthcare providers. The electronic health record was created to increase communication and information between healthcare providers as well as reduce replication of information and make providers aware of other potential conditions, medications, and diagnoses that may affect overall healthcare. Additionally, data from the EHR can be extracted for use in program evaluation and assessment of quality improvement practices.

Current Procedural Terminology (CPT): For billing purposes, CPT codes are used to designate the type and amount of time a healthcare service was delivered to a patient. CPT codes are available for all types of healthcare providers. Mental/behavioral health CPT codes are for use by licensed behavioral health providers and cover intake sessions, testing, individual, family, and group treatment services.

International Classification of Diseases and Related Health Problems, 10th Edition (ICD-10): This document, published by the World Health Organization, covers nearly 70,000 healthcare diagnoses. Mental/behavioral diagnoses are discussed in ICD-10 Chapter 5 (of the twenty-two overall chapters). Insurers, Medicaid, and Medicare generally require that billings indicate a diagnosis to justify medical need for services.

Diagnostic and Statistical Manual of the American Psychiatric Association, Fifth Edition, Text Revision (DSM-5-TR): Closely aligned with the mental health chapter of the ICD-10 are behavioral health diagnoses of the DSM-5-TR (APA, 2022). Diagnoses are coded by number and specifically deal with billable mental/behavioral health conditions. DSM-5-TR diagnoses generally mirror those from ICD-10.

Specialty Care: This term refers to services provided by physicians or other health providers (both medical and behavioral) that have had advanced fellowship training beyond medical or graduate school education and residency/fellowship in an area of specialized care. Some examples of specialty physicians include cardiologists, surgeons, pulmonologists, neurologists, child psychiatrists, etc. Even within a specialty there are "subspecialists." For example, within surgery can be found neurosurgeons, hand surgeons, cardiac surgeons, cosmetic surgeons, etc. In the field of behavioral health and physical health, specialty care might be provided by geriatric psychiatrists, addictionologists, developmental pediatricians, neuropsychologists, child psychologists, etc. Specialty mental healthcare is also provided in psychiatric hospitals, residential treatment programs, drug and alcohol treatment centers, etc.

Accountable Care Organization (ACO): This term refers to a healthcare system that assumes responsibility for all the healthcare needs of a defined population of patients. Accountable Care Organizations are usually physician-led and focus upon value and meeting quality standards. Reimbursement for services is prospective and based upon a per-patient-per-month payment schedule versus fee-for-service reimbursement. Value is based upon quality of patient care, outcomes, and economic efficiency versus quantity of services provided.

Fee for Service: This term describes the most currently used system for payment to healthcare providers for service delivery. The focus in fee-for-service reimbursement is upon the quantity of services provided such that numbers of procedures and patients seen are common measures of productivity and value to the healthcare practice.

Value-Based Health Care: A relatively new yet increasingly popular concept is that of value-based healthcare. Currently there is no one agreed upon definition of what constitutes value-based care. These models often account for cost reduction, quality improvement, patient satisfaction, and improved health outcomes in the delivery of services and base models of payment or reimbursement for services on such metrics.

Relative Value Units (RVUs): A measure of value used in the Medicare system to determine the amount of reimbursement for services to standardize rates. Units are based on a formula of physician work, practice expense, and malpractice expense and multiplied by a geographic practice cost index. For medical providers, these rates are set by the American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC).

Provider Roles in Integrated Primary Care

Behavioral Health Clinician/Provider (BHC/P): These are "umbrella" terms used to identify licensed professionals trained in one of the behavioral health professions. The terms apply to psychiatrists, doctoral-level psychologists, master's degree certified social workers, mental health counselors, marriage and family therapists, and psychiatric nurse practitioners.

Primary Care Provider (PCP): Within primary care practice, this term describes individuals who are licensed to practice medicine, independently or under the supervision of another medical practitioner. Included in this category are physicians (MDs—Doctors of Allopathic Medicine or DOs—Doctors of Osteopathy), nurse practitioners, and physicians assistants. All these practitioners are licensed to prescribe medications, including psychotropic meds.

Licensed Psychologist (LP): These letters refer to psychologists who are licensed to practice independently in the field of behavioral health. Psychologists have doctoral degrees indicating four to five years of academic graduate preparation plus an internship and one year of postgraduate supervision or fellowship training. Psychologists can have degrees indicating a PhD (Doctor of Philosophy in Psychology) or a PsyD (Doctor of Psychology). Psychologists are fully licensed upon graduation from training programs in Clinical, Counseling, or School Psychology and one year of postdoctoral supervision.

Licensed Psychiatrist: Upon graduation from medical school and completion of a four-year residency in psychiatry, full licensure to engage in psychiatric practice is awarded. Psychiatrists hold either an MD (Doctor of Allopathic Medicine) or a DO (Doctor of Osteopathic Medicine) degree. Specialties in psychiatry involve additional training and include child-adolescent, forensic, and geriatric psychiatry, among others. Most psychiatry training programs focus upon biologically based treatments and medication management.

Provisionally Licensed (Psychologist, Counselor, Social Worker, Marriage and Family Therapist, Mental Health Practitioner): Upon graduation from a graduate behavioral health training program, many states provide licensure at a provisional level, indicating that the provisional provider is under supervision for at least two thousand hours (psychologists) or three thousand hours (social workers, MFTs, counselors). After the required post-graduate supervision and passing a national examination, behavioral providers can become fully licensed. Amounts of supervision may vary state to state and scope of practice. In some states, for example, provisionally licensed behavioral health practitioners can bill Medicaid or selected insurers. It is recommended that graduates become familiar with their state's licensing standards and related scope of practice, as well as state reciprocity for states they may practice in, upon graduation from their training program.

Licensed (Psychologist, Social Worker, Marriage and Family Therapist, Counselor, Mental Health Practitioner): Licensed behavioral health providers can independently bill Medicaid and health insurance companies for delivery of behavioral health services to patients. Degree of independence as a mental health provider varies from state to state. In some states, only psychologists or medical personnel (MDs, DOs, PAs, or NPs) can diagnose mental health disorders. Master's level clinicians with extended training and experience can become "independent mental health practitioners," which then allows them to diagnose mental health disorders. Again, these practices vary state to state, and providers need to familiarize themselves with these policies and statutes.

Medical Assistant (MA): Also known in some states as a “clinical assistant” or “healthcare assistant,” a medical assistant is an allied health professional supporting physicians and other healthcare professionals, usually in a clinic setting. MAs update and file patient medical records, schedule appointments, take medical histories, collect specimens, assist physicians during exams, etc. Medical assistants receive certification from allied health training programs, usually requiring a year or less of educational preparation.

Licensed Practical Nurse (LPN): An LPN is a nurse with one to two years of medical education. Licensed practical nurses work under the supervision of a physician or a registered nurse. LPNs commonly work in nursing homes or in primary care clinics where supervision is available.

Registered Nurse (RN): An RN is a nurse who has graduated from accredited nursing program, generally at a minimum of two to three years of medical education, and who has passed the national nursing examination. Registered nurses work in clinics and in hospital settings. RNs are licensed professionals with a scope of practice that may vary state by state.

Bachelor of Science in Nursing (BSN): This designation is for nurses who have completed requirements for the RN certificate but have an education that includes a Bachelor of Science in Nursing degree. Some colleges do not offer RN training alone but require bachelor’s degrees for graduation, usually requiring four years of study and a series of clinical practicums. Some nurses with an RN degree return to school to complete the BSN. In general, the BSN is the minimum required for nurses wishing to get into management positions within a hospital or healthcare system.

Advanced Practice Registered Nurse (APRN): This term is used to designate nurses who have advanced training leading to a master’s degree in nursing. There are a variety of APRN training programs leading to clinical certification in a specialty area of nursing or in an area of research. The APRN that is most applied is the NP, or Nurse Practitioner degree.

Nurse Practitioner (NP): This title recognizes a subset of applied advanced practice registered nurses who are licensed and trained to assess, order and interpret tests, diagnose, and treat medical conditions. NPs also have prescriptive privileges. In many states, Nurse Practitioners can practice independently and do not require physician supervision. NPs are increasingly becoming partners in primary care practices and in some states have developed their own medical clinics. Nurse practitioners may also have a specialty designation as a Family Medicine NP, Pediatric NP, Psychiatric NP, etc.

Psychiatric Nurse Practitioner (Psych NP): The psychiatric nurse practitioner has specialized training in assessing, diagnosing, and treating mental health conditions. This designation requires an APRN master's degree or a certification beyond an existing master's degree. In many states, psychiatric nurse practitioners are independent and can prescribe psychotropic medications and design treatment programs for patients with behavioral health needs. Psychiatric NPs typically work in hospital settings but increasingly are entering into independent practice.

Physician Assistant (PA): In recognition of the need for additional medical personnel trained to assist practicing physicians, PA programs started within the military establishment. The physician assistant receives two to three years of medical education and works under the supervision of a collaborating medical doctor. PAs can diagnose, prescribe, and treat medical conditions. PAs are most commonly found in primary care clinics, but there has been an increase in the number of physician assistants who receive additional training and work in specialty care clinics.

Models of Integrated Behavioral Health in Primary Care

The following descriptions come from Unutzer, 2014.

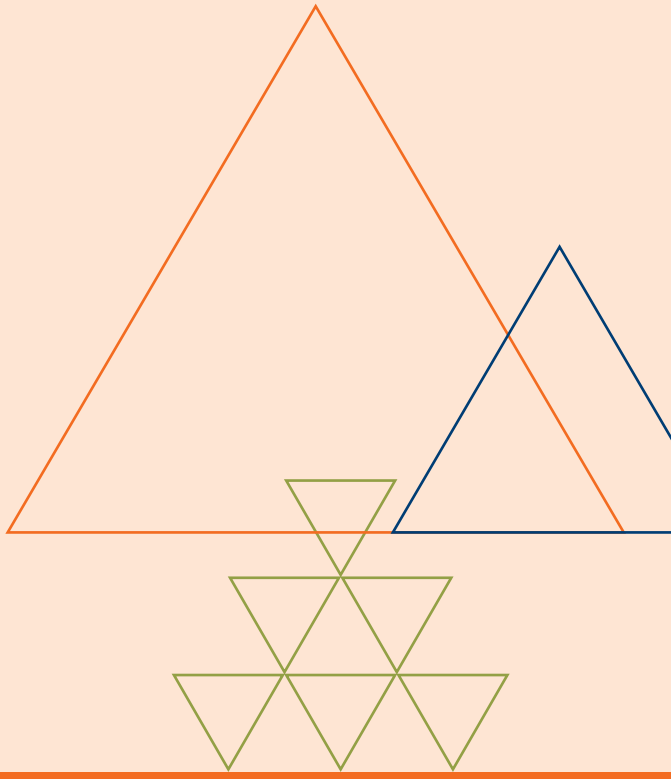
Primary Care Behavioral Health Model (PCBH): This term describes a model of integrated care that involves placement of a licensed behavioral health professional practicing within the primary care practice. The primary care behavioral health model involves focusing on population health, joint care with primary care medical providers, screening, brief therapies, and referrals for those patients with most severe behavioral conditions. Like a primary care physician, the PCBH provider becomes the patient's "behavioral health doctor" for current and future behavioral difficulties that may arise.

Collaborative Care Model (CoCM): In this model of integrated behavioral healthcare, a registered nurse, bachelor's level social worker, or a licensed behavioral health clinician provides mental health screening and triage for patients with behavioral health issues to consulting psychiatrists. Primary care physicians then receive telehealth consultation from a collaborating psychiatrist. Interventions are implemented by the primary care physician with advice from the consulting psychiatrist, usually involving medication management. This model has mainly addressed adult depression and anxiety disorders. The model also creates "registries" of patients with these disorders. Registries ensure that patients are followed-up with, and "stepped care" is provided when current treatments prove to be less effective in reducing symptoms.

“HYBRID” Model of Integrated Behavioral Health in Primary Care: Increasingly, although not widely implemented, there has been movement to combine the best elements of the Primary Care Behavioral Health and Collaborative Care models of IBH (Unutzer, 2014). Although there seem to be opposing processes and treatment goals between the PCBH and CoCM approaches, they are not incompatible. In several of our integrated clinics, for example, licensed PCBH clinicians provide brief, evidence-supported services for patients referred by primary care physicians. Consultation backup can be obtained from a team of a consulting psychiatrist, psychiatric nurse practitioner, or developmental pediatrician. Each of these prescribers rotates on an on-call schedule of availability. In this arrangement, 90 percent of patients are treated by behavioral health clinicians and primary care medical staff. Recommendations are available from the team of psychiatric providers for medication management, hospitalization, or referral for long-term, intensive therapies for severe mental health disorders.

Tips and Take-Home Points

- There are varying degrees of integrated care, ranging from coordination to co-location to full integration.
- Behavioral health services are delivered by a variety of healthcare professionals, including both behavioral health clinicians and primary care medical providers.
- Medical professionals licensed to prescribe psychotropic medications include physicians, nurse practitioners, physician assistants, and in some states, specially trained psychologists.
- Behavioral health providers (non-prescribing) include licensed psychologists, counselors, social workers and marriage and family therapists.
- Primary care providers are trained in general medicine and are the first (primary) source of healthcare for patients, including those with behavioral disorders.
- Payment for behavioral health care generally involves fee for service and requires licensure, being paneled by an insurer, a diagnosis (Dx) from the ICD-10 or DSM-5-TR (APA, 2022), and a CPT code identifying the type and duration of services delivered.



Chapter 3

Developing an Integrated Primary Care Clinic

This chapter is written for behavioral health practitioners planning to integrate pediatric behavioral healthcare into primary care practices (Family Medicine or Pediatric).

We offer suggestions for initiating discussions with medical practitioners and/or clinic administrators. If you are already part of the primary care practice, this chapter may not be as valuable for you but may provide some guidelines for future expansions into additional clinics.

Getting into the Primary Care Clinic

There are many types of administrative structures involved in primary healthcare provision. Many primary care practices are owned by a hospital or healthcare organization. These primary care practices are usually scattered throughout the local community, have centralized administrative supports (scheduling, electronic health records, billing, etc.) through the healthcare system, and make referrals for specialty medical care to the parent hospitals where specialty care clinics and staff are located.

Other primary care providers may be part of a network of primary care practices, share administrative supports and billing services, and are able to refer to specialists from a variety of hospital systems. Still other primary care practices, particularly those in rural areas, are independent, privately owned, and provide their own scheduling, record-keeping, and billing services. Due to their remote locations, these practices may refer to specialty care from a variety of associated hospitals across a wide geographic area. In some cases, these primary care practices have regular visiting specialists.

In our experience, the most expeditious method for integrating behavioral health services into primary care is to approach independent, privately owned medical clinics. In these settings, decisions can be readily made by physicians and/or clinic owners in relatively short periods of time without ponderous

layers of administrative oversight. By contrast, in larger hospitals or healthcare systems, there are generally significant delays in implementation due to the greater numbers of decision makers and internal bureaucracies that need to review and approve the integration of behavioral health into their primary care practices. Integration can be sold to larger systems but will require more time and effort to achieve. On the positive side, once a healthcare system's decision has been made to adopt integrated behavioral health, there will be multiple opportunities to expand into primary care clinics owned by the system.

One of the easiest ways to initiate discussion about integrated care is to simply ask your own primary care provider how behavioral health services are delivered for her or his patients.

Increasingly, primary care physicians are recognizing the need for having behavioral health services available within their clinical practices. Most physicians and/or healthcare systems, however, have little knowledge of where or how to find behavioral health practitioners, particularly those trained in integrated care. There are several "methods" designed to facilitate the integration of behavioral health into primary care medical practices. The following are suggestions for starting the dialogue with physicians, clinic managers, and/or administrators regarding how to integrate behavioral health into their medical practices.

Patient Status

In our experience, one of the easiest ways to initiate discussion about integrated care is to simply ask your own primary care provider how behavioral health services are delivered for her or his patients. Most physicians will be honest in indicating how their patients with behavioral concerns are treated within their practice or how and to whom the patients may be referred. Some PCPs will indicate that they themselves provide behavioral healthcare within the practice. More frequently, however, practitioners will indicate community mental health referral sources and share whether or not they are satisfied with care being provided for their patients. If they are satisfied with the relationship with a local provider or are concerned about possibly alienating their contacts, possibilities for integrating behavioral healthcare into these practices may be limited.

The majority of primary care physicians/providers report difficulty in getting access to behavioral health services for their patients (Porras-Javier, Bromley & Lopez, et al., 2018). Lack of available providers, difficulties in scheduling, lack of communication from referral sources, and timeliness of appointments for their patients have all been mentioned as sources of concern by primary care providers. This provides an opportunity to discuss the possibility of having a behavioral health provider within the practice and to offer a brief presentation to the clinics' primary care and administrative staff. It is also helpful to be able to leave some information about one's own qualifications and training in integrated primary care (IPC), as well as data from the research literature on the effectiveness of integrating behavioral health into primary care practices.

If the physician or clinic manager demonstrates interest, scheduling a follow-up visit is crucial, along with a request to provide a brief presentation to the clinic and staff. Busy clinics can usually only afford a fifteen to thirty-minute break, typically over the lunch hour, for a discussion. Keeping the presentation brief and being prepared to answer questions on the advantages of integration and how an integrated behavioral health service would function should be anticipated. A sample IPC presentation that highlights a description of integrated care, behavioral health problems addressed in IPC, how integrated care functions, and advantages for the primary care practice and patients accompanies this training manual in the supplemental materials. Additionally, a one- to two-page handout of behavioral health services can help answer questions from the primary care practice providers and staff.

Personal and Professional Relationships

Another method of accessing primary care providers is through personal contacts with friends, family, and/or professional colleagues. Using your relationship with acquaintances can help to identify primary care practices that may be open to integrating a behavioral health provider into clinic operations. Our very first clinic, established more than twenty years ago, was developed based upon a referral from a personal acquaintance (a high school friend) who was familiar with physicians from a local pediatric practice. Contacts through this individual led to introductions to the physicians in the practice, a presentation, and eventually to the establishment of an integrated clinic.

Announcements/Presentations to Medical Provider Associations

Most primary care practitioners belong to local associations of medical providers. These groups typically meet at regularly scheduled intervals to socialize, obtain continuing education credits, and share new developments in healthcare delivery. Contacting local, regional, or state organizations can provide an opportunity for behavioral health providers to make presentations or lead discussions of behavioral services available at professional association gatherings. With an increasing focus upon behavioral health and primary care integration, many medical associations are now open to having speakers from behavioral health professions. If this opportunity is available, asking audience members with an interest in behavioral health to leave contact information is advisable and can lead to a follow-up meeting or integrated care presentations to their practices.

Referral Streams from Primary Care Physicians/Practices

If currently practicing within a private behavioral health practice or community behavioral health agency, there are often identifiable patterns of behavioral referrals that consistently come from particular PCPs or medical practices. A review of patient sources from the past twelve to twenty-four months can provide data on referral patterns. In some cases, relationships with the primary care referring physician/provider may have already been established. These providers are generally open to improving access to behavioral health for their patients and can serve as “champions” for the integration of behavioral health within their clinical practices. Cultivating relationships with these champions can be established through individual meetings, notes or letters thanking them for their referrals, providing physicians with information on progress of their patients, referring back to primary care practitioners for any potentially needed medications, and offering written literature or handouts on basic patient behavioral management that can be used in primary care. Once this relationship has been established, a request to the championing physician or administrator for a presentation to the clinic staff can be made.

Cold Call or Letter of Introduction

On occasion, when entering a new community or seeking a partnership with a primary care practice with which there has been no previous contact, a letter or cold call to a primary care provider may be employed. (A sample letter with suggested information content is included in the supplemental materials.) We

have found that face-to-face cold calls to a clinic PCP to be the more successful of these two strategies. If one is unable to contact a PCP within the practice, a cold call to a clinic administrator or manager is another option, as these individuals are often involved in decision making and are assigned to "protect" their PCPs from time-consuming outside requests and phone calls. In all of these scenarios, it is important to:

- Introduce yourself and your credentials.
- Describe the integrated behavioral health model and how it functions in primary care practices.
- Provide information on your training and experience in integrated care.
- Point out the advantages for patients and the primary care physicians of having a behavioral health provider within the practice.
- List behavioral treatment and assessment activities that can be provided including screenings, diagnosis, brief therapy, and appropriate referral.
- Offer to meet with the physician and clinic staff to do a brief presentation and answer any relevant questions.

Presentation to Primary Care Providers and Staff

In all the scenarios described above, a key component is scheduling an in-person meeting with the "leadership" of the primary care practice. Most clinics have identified a managing physician or a medical director who is a decision maker and is key to introducing the model of integrated behavioral health professionals to the practice. This practitioner/champion generally becomes the point of contact for behavioral health providers, although some contacts may be designated or assigned to a clinic manager in a busy practice or in a healthcare system. If possible, it is important for the behavioral health professional who will be working in the clinic to attend the presentation. This allows clinic leadership to have a chance to meet and potentially assess how the behavioral health provider will fit into the practice.

Most important in the presentation to the PCPs is an emphasis on the positive value of having behavioral health available within the primary care practice. Not only are there benefits for patients but also for medical providers and support staff within the clinic. You should be prepared to address three major topics that

are typically of concern to practicing physicians, clinic managers, and administrators. These three areas generally cover:

- Costs to the clinic that may be incurred by having an integrated behavioral health provider
- Space needs of the behavioral health clinician in the practice
- Support staff resources requirements

Most important in the presentation to the PCPs is an emphasis on the positive value of having behavioral health available within the primary care practice.

The following are some tips for an effective presentation to practitioners and clinic staff.

Brief. Keep in mind that, in a busy clinic, primary care providers may see anywhere from twenty-five to forty patients each day. Appointments are generally scheduled three to four per hour with very brief breaks for lunch. A presentation must be brief, preferably entertaining, and one that provides basic information and supportive data. Usually, a twenty to thirty-minute presentation is an outside limit for available physician time and for sustaining attention. Plan on a brief presentation with time for questions from the PCPs and managers.

Be Informal. This is not the type of presentation one would do for a conference or for teaching a class. Open by inviting interruptions and questions that might arise during the presentation. Often audio-visual equipment will be unavailable. It is preferable that questions are answered during the brief talk versus missing the opportunity to respond at the end of the presentation when the providers need to get back to work.

Provide Brief Handouts. Physicians and other primary healthcare providers in the clinic will be interested the types of behavioral services that can be offered. It may be helpful to ask what some of the most common behavioral health concerns are raised by their patients. A handout should cover common concerns addressed in IPC, screening, and short-term behavioral interventions. Information on what families can expect in terms of assessment, typical number of sessions, and referrals to specialty care should also be discussed. This document should be condensed into one to two pages and be easy to digest.

Promote Yourself. It is acceptable to self-promote your educational background and your experiences or training, as well as that of colleagues in your agency, that might be applicable to patients seen in the primary care clinic. This information can be included in the handout provided to the clinic staff.

Provide Contact Information. Phone numbers and email contact information can be provided on a business card or included on the behavioral services handout. Inclusion of cell phone information should be provided if you are not readily available through an office or home phone.

Demonstrate Need. In your presentation, provide information and data showing that many patients with behavioral health needs have difficulty gaining access to services and are not receiving adequate behavioral healthcare. This can present an opportunity for audience interaction through asking providers, nurses, and staff about the types of current behavioral health patients being managed in the clinic.

Discuss Space Needs. Physicians and clinic managers may be concerned with how a behavioral health provider will physically fit into an existing busy practice. In most practices, primary care providers will have a nurse assigned to them plus three to four exam rooms. Fortunately, behavioral health providers do not require much physical space, and when possible (for example, when a PCP has a day off in the middle of the week), seeing patients in exam rooms is preferable. Minimally, behavioral health clinicians require a single room for patient care and office space. In many clinics there is shared space for report-writing, consultation between providers, and computer access. The message to clinic staff is that little space is required by behavioral health providers and, most importantly, should be within the clinic's "patient flow" so behavioral health clinicians are consistently

available to both patients and physicians. Being in the patient flow easily allows for warm handoffs (in person introduction and transfer of care to behavioral health providers) and hallway consultations.

Include Support Staff Needs. The third major concern of primary care practices relates to the amount of support staff resources space required when adding a behavioral health clinician to the practice. PCPs and clinic managers will often compare the support needs of behavioral health clinicians to those of medical providers who see three to four times as many patients daily. Visiting medical specialists (such as surgeons, pulmonologists, cardiologists, etc.) require nursing support, the use of several exam rooms, dictation equipment, conference space, labs, etc. By comparison, in a well-run integrated primary care clinic, support staff needs are minor. Minimally, front office staff check patients in, alert behavioral health providers that patients are present, gather insurance information, and schedule follow-up visits. If the behavioral health professional is employed by the clinic or is contracting for additional services such as billing and collections, additional supports can be paid for from behavioral health collected revenues. For a busy clinic of three PCPs seeing seventy-five to one hundred patients per day, the addition of a behavioral health provider seeing seven to ten patients daily presents a minimal burden upon support staff.

The message to clinic staff is that little space is required by behavioral health providers and, most importantly, should be within the clinic's "patient flow" so behavioral health clinicians are consistently available to both patients and physicians.

Clarify Roles. Clarifying the role of the behavioral health provider in an integrated clinic should be addressed in a presentation to the primary care clinic or healthcare system. Behavioral health professionals in IPC are taught to be open to any and all types of referrals from clinic physicians, schools, the community, and other medical practices. Through coordinating care with primary care physicians in the clinic, approximately 85 percent to 90 percent of pediatric patient behavioral health concerns can be successfully assessed and treated using brief interventions. Approximately 10 percent of patients may require specialty care, such as longer-term treatment programs for outpatient alcohol abuse or services for children with autism, eating disorders, or survivors of suicide attempts. The remaining 2 percent to 5 percent of referrals may require hospitalization or residential treatment for schizophrenia, major depression, bipolar disorder, etc. It should also be emphasized that the primary care behavioral health clinician is not in a position to address court ordered therapies, child custody evaluations, or evaluations of competency to stand trial. Such endeavors are clearly out of the scope of brief therapies and may require months to years of treatment.

Provide Data on the Benefits of IPC. There are many potential benefits related to IPC that can be included in a presentation. Brief discussions of data that demonstrate these benefits helps to provide a clear justification for integrated practices. Remember to keep it brief and focus on contextual data as much as possible; for example, include data from rural communities when talking with clinics in rural areas.

> ***Benefits for patients.*** The major benefits for patients receiving behavioral health services within a primary clinic involve the comfort of receiving behavioral health services within the primary care office, a reduction in potential stigma of receiving mental health services, the coordination of behavioral and physical healthcare, and improved access to behavioral healthcare. For example, a recent study found that patients with anxiety disorders were more likely to access care in an integrated care clinic (Valleley et al., 2020).
>
> ***Benefits for physicians and related healthcare providers.*** A major concern expressed by PCPs is the lack of ability to have their patients seen in a timely manner.

Integrated care provides a ready internal referral source for physicians, NPs, and PAs, plus the capacity to triage patients who are most in need of behavioral health services. Behavioral health clinicians can assist with crisis intervention, suicidal ideation, and risk assessment. Provision of behavioral health in primary care can also save time for primary care providers, as it allows them to increase their clinical efficiency. Recent research suggests that pediatrician efficiency improved significantly during well-child visits when on-site behavioral health services were available within the practice (Lancaster, 2020).

Physician/medical provider satisfaction. One of the factors in the "Quadruple Aim" of healthcare provision is improved satisfaction and comfort for healthcare providers. Findings have indicated that physicians who have adopted an integrated care model have improved levels of job satisfaction, increased confidence with identification and management of behavioral problems of their patients, and additional time to spend on their patients' medical issues.

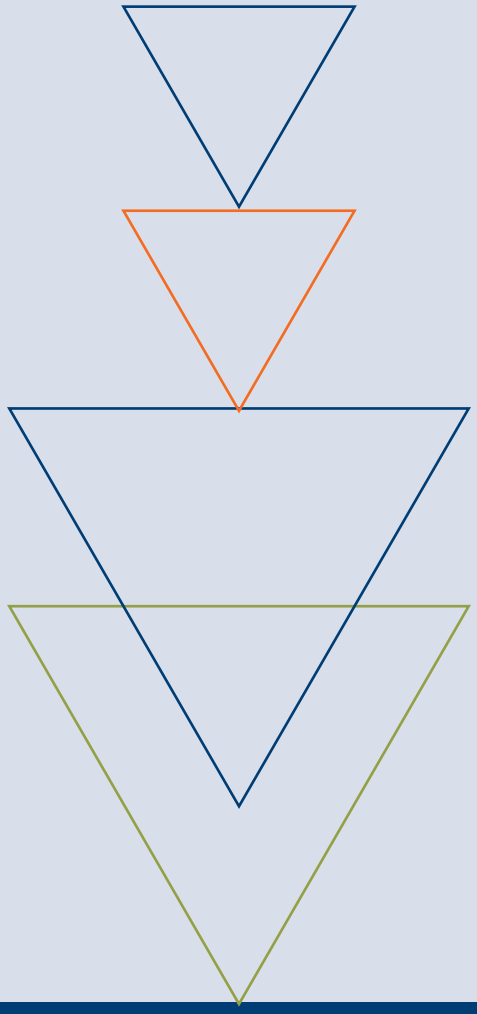
Cost Offset. Fiscal resources associated with IPC are the primary concerns of medical directors, physician leaders, PCPs, and administrative personnel within the primary care clinic and/or the healthcare organization. As seen in the chapter related to business models, there are a variety of methods to pay for and/or minimize any costs incurred through integration of behavioral health. Contractual agreements, rental of clinic room space, or employment by the clinic are all business options for integrating behavioral health into the primary care clinic. It is important during your presentation to discuss the medical cost offset provided through integrated behavioral healthcare. Physicians, NPs, and PAs can be more productive and efficient in their practices when a behavioral health provider is available to handle patient behavioral concerns that are often time-consuming. Overall, the message to the primary care practice is that there are few additional costs to the clinic and that additional revenues generated by physicians and healthcare providers more than adequately

offset any minor initial costs. For example, a study of medical cost offset found that five PCPs in a rural practice were able to see 42 percent more patients and billed $1,142 more on those days when a behavioral health provider was present and providing services within the clinic (Gouge et al., 2016).

Improved Show Rates. A common concern among primary care providers is follow-through when patients are referred for behavioral health evaluation and treatment. PCPs and staff often spend a significant amount of time locating referrals for their patients in need of behavioral healthcare. Community mental health centers, human service agencies, and private psychology, social work, marriage and family, and counseling practices are all sources of referral for primary care practitioners. However, when primary care providers refer patients to off-site behavioral health, follow through rates are as low as 5 percent to 50 percent (e.g., Asarnow & Miranda, 2014; Briggs-Gowan, Horowitz, Schwab-Stone, et al., 2000; Farber, Ali, Van Sickle, et al., 2017). By contrast, various studies have shown that 80 percent to 95 percent of patients referred to an integrated behavioral health professional within the primary care practice follow through with initial sessions and are much more likely to complete treatment (e.g., Valleley, Meadows, Burt, et al., 2020). Berliner & Kolko, (2016), employing a modified collaborative care model, found that 99 percent of patients made their initial appointment when behavioral health services were provided within primary care practices, and 77 percent completed treatment. By comparison, only 56 percent of patients referred to community behavioral health providers made their first appointment, and only 12 percent completed treatment.

Tips and Take-Home Points

- There are multiple methods for introducing primary care practices to integrated behavioral health including: contacting one's own personal primary care provider, obtaining PCP introductions through colleagues, family members, and/or friends; examination of primary care patient referral patterns; letters of introduction; cold calls; and through presentations at local professional medical association meetings and/or conferences.
- Identify a "champion" within the primary care practice as a point of contact and offer to give a brief in-person presentation to medical directors, PCPs, staff, and administrators.
- Be prepared to respond to three main areas of concern: costs to the clinic, space requirements, and support staff needs.
- Present data on the benefits of integrated behavioral healthcare for patients and providers—including improved access to care, cost efficiency, time savings, and patient satisfaction.



Chapter 4

Supportive Data Collection for Integrated Primary Care

Procedures for initiating and sustaining integrated primary care are largely dependent on the structure and size of the primary care organization.

As noted earlier, there are a variety of strategies and approaches for entry into primary care practices. The easiest and most direct method occurs when the primary care practice initiates contact with a behavioral health practitioner or agency. Conversely, when behavioral health providers need to originate contact, there are different strategies needed for approaching small, independently owned clinical practices, organizations of primary care providers, or large healthcare systems that own multiple primary care clinics (see Chapter 3). Common to these approaches, however, is a need to collect information that both demonstrates the value of integrating behavioral health into primary medical clinics and supports sustainability of integrated primary care practices over time. This chapter provides some guidelines for the collection of information that is both supportive and, in most cases, easily obtainable. We discuss rationales for data collection as well as some of the different barriers that may need to be addressed in obtaining program evaluation information.

Clinic managers, primary care providers, and administrators are often reluctant to make a long-term commitment to changes in service delivery that they deem as potentially costly, requiring valuable clinic space, or see as a "drain" on current support staff resources in the primary care practice(s). Some organizations have eager primary care providers but lack the knowledge for integrating behavioral health (IBH) into their clinics. When such ambivalence is detected, an organizational assessment followed by a proposal for a short-term (one-year minimum) "pilot project" can be effective in introducing behavioral health into the practice. A pilot project enables the primary care organization to evaluate the benefits of the program without a long-term commitment. Data can then be gathered to demonstrate whether or not the pilot project improves access to behavioral healthcare, is of benefit to patients and medical providers, is effective in addressing behavioral problems presenting in the primary care clinics, and is economically feasible.

Organizational Assessment of Readiness for IPC

There are several assessment tools designed to evaluate organizational readiness for adopting an integrated primary care practice. These measures can be helpful in creating a framework for moving forward with the integration of behavioral healthcare. Often, selling the idea of integrated care to a primary care team requires little to no effort because they see patients every day who can benefit from behavioral health services. It is common for primary care providers to remark that they have a list of current patients in need of behavioral health care. An organizational assessment may not be necessary in these situations because decision

makers are already sold on the idea. This is more often the case in independently owned primary care practices or organizations with a small network of primary care clinics where the practicing physician(s) own the clinics and make both programmatic and budgetary decisions.

In larger healthcare systems, however, convincing administrators may be a more difficult task and may require an evaluation that highlights the organization's readiness to integrate care. Key information from an organizational assessment, if positive, can then lead to acceptance and implementation or, at a minimum, to a "pilot project" in one or more primary care clinics from which information can be collected. Data can be collected from the pilot program in terms of value to the practice and patients, acceptability for addition into the primary care clinics, cost-effectiveness, and any alterations in practice that need to be made. There are a number of organizational assessment tools in integrated primary care for assessing readiness to move forward with integrating behavioral health into primary care. Included in our supplemental guide are sample data collection measures of readiness for integrated primary care and references for published scales.

Measuring Impact and Effectiveness in IPC

Once a primary care clinic or healthcare organization has agreed to support integrated primary care, establishing and maintaining an ongoing system of data collection is vital for sustaining viability within the primary care practices. This information can be used to demonstrate the benefits of IPC to medical providers, the practice, and patients as valuable, cost-efficient, and effective in managing patient behavioral concerns. The key is to gather administrative and satisfaction data that can be easily collected and presented to decision makers regarding overall program effectiveness and acceptability for the practice. Collected data can also be used to persuade leadership to hire behavioral health providers as

employees or expand numbers of behavioral health providers for clinics. In the absence of a system of supportive information, we have witnessed behavioral health provider contracts and employment canceled by medical practices when clinical revenues were was not sustained or grant support ended. The remainder of this chapter provides suggestions for data collection within the primary care practice through collaboration between integrated behavioral and physical health providers. Data collection and analysis can support the viability and value of integrated primary care to physicians, administrators, and clinic managers.

Number of Patients Referred to Behavioral Health Providers

Some estimates indicate that anywhere from 14 percent to 21 percent of patients have a diagnosable behavioral disorder. For example, in a pediatric practice with three primary care practitioners and a panel of 3,500 enrolled patients, estimates would suggest that anywhere between 500 and 750 individual patients and their families would need some type of behavioral intervention. Most primary care medical providers, especially those in underserved and rural areas, typically provide behavioral suggestions using anticipatory guidance, handing out pamphlets provided by drug companies, offering limited counseling, or referring to community behavioral health providers or agencies. When behavioral issues are brought up by patients or parents in medical visits, primary care physicians typically spend over twice as much time on behavioral health issues as they do with acute and chronic healthcare appointments. Additionally, physicians can only bill at significantly lower rates of reimbursement for sessions involving behavioral health intervention. (Meadows et al., 2011). These data demonstrated that behavioral health service provision by physicians has a negative impact upon overall physician and Relative Value Units (RVU) billing generation.

Clinicians can collect the number of referrals for behavioral health by simply counting and recording the number of warm handoffs, hallway consultation requests, and patients referred or scheduled for behavioral health services. Several factors impact referral rates in primary care clinics. Initially, until a behavioral health clinician has “proven” himself or herself, referrals may be infrequent. In our experience, for example, many primary care physicians are trained and feel obligated to provide all healthcare services to their patients, including behavioral health. They sometimes view psychologists and other behavioral health providers as “specialty” referral sources for only the most severe patients (e.g., schizophrenia, suicide threat, major depression, etc.). PCPs may also have had negative experiences with community behavioral health providers such as difficulties in getting their patients scheduled, poor communication from behavioral health providers, or having their patients dissatisfied with behavioral health services provided. A written listing or brochure describing available behavioral health services can help define the scope of behavioral health practices and assist with establishing referrals from primary care physicians. See the sample brochure provided in the supplemental guide.

Some estimates indicate that anywhere from 14 percent to 21 percent of patients have a diagnosable behavioral disorder.

Number of Patients Seen and Referral Sources

As is presented in the next chapter on business models, the productivity level for behavioral health providers (and the indirect influence of IPC on productivity of collaborating physicians) should be assessed to justify initiating and sustaining behavioral health integration in the primary care clinic. Keeping a record of the number and type of patients seen, assessed, and treated in the clinic, as well as those referred for outside specialty care should be a goal for a pilot project and for ongoing evaluation of the integrated care approach. In our experience, referrals to behavioral health may come from a variety of sources including in-house providers, other community medical practices, hospitals, schools, parents, and private behavioral health practices.

Keeping track of the source of referrals, including from each of the individual practitioners within the clinic, can provide a measure of acceptance of the integrated care model within the practice and in the community. In some instances, we have found degrees of reluctance to make referrals to behavioral health from individual healthcare providers. With the development of relationships within the clinic, however, these barriers are usually overcome. In one case, for example, a physician was initially reluctant to make referrals but, after seeing a successful outcome with another colleague's patient, began to make referrals and eventually became the behavioral health champion for that integrated primary care practice.

Although behavioral health professionals may initially welcome referrals from other medical practices, schools, agencies, etc., the overall volume of patients being served within the primary care clinic may require that the behavioral health clinician either discontinue taking outside referrals or give preference to patients referred from within the practice. As the patient base for behavioral services increases, expansion of additional behavioral health clinicians may need to be addressed with providers within the primary care clinic. The U.S. Air Force recommendations for behavioral health staffing suggest the requirement of one behavioral health provider for every 3,500 patients served in the primary care practice (Robinson & Reiter, 2016). In our experience with pediatric practices, this estimate may need to be reduced to 2,500 patients per behavioral health provider due to the extensive early intervention and parent training involved in integrated behavioral health care for children and adolescents.

Wait Times

Patient satisfaction is a major concern of primary care providers. When patients are scheduled to see their primary care physician but must remain in the waiting area (sometimes due to patient behavioral issues) to receive care, consumer satisfaction ratings may decrease. If 20 percent of patients with behavioral concerns typically require additional physician time, waiting room time can increase to as much as an hour, leading to frustration and patient dissatisfaction. Data on wait times can be gathered by front office staff on random days or through surveys of patient satisfaction with care. In our experience, waiting room times tend to decrease when a behavioral health professional is available, which can improve patient satisfaction. At the same time, primary care providers can see more patients and increase their patient volume and revenues for the clinic. (Gouge, Polaha & Rogers et al., 2016).

Other wait time data that is valuable for supporting integrated behavioral health is "wait list" information. When new patients are referred for behavioral health services but are consistently required to wait three or more weeks for an appointment, numbers of missed appointments increase, and patient satisfaction with services decreases. To address this issue, behavioral health providers may need to limit follow-up session time, discuss hiring additional clinical support, establish a triage system with referring physicians so that patients in most need can be seen first, or cease taking referrals from outside the primary care clinic. While having a wait list is positive in that it demonstrates needs for behavioral health services, managing additional volume can be problematic for both the behavioral clinician and the medical practice.

Patient and Provider Satisfaction Measures

For patients seen in a primary care clinic by a behavioral health provider, collecting patient satisfaction data can be quite valuable in supporting and maintaining the integrated behavioral health in a primary care model. If consumer satisfaction measures are already part of the healthcare system or primary care practice, simply adding three or four questions regarding behavioral health services can

provide valuable patient information. If not part of an existing system of feedback, consumer satisfaction data can be gathered using a brief form on a quarterly basis for patients receiving behavioral health services at the time of their appointment or through a mailing to a random sampling of patients receiving behavioral health services over the past six to twelve months. We have included a sample consumer satisfaction measure in the supplemental guide.

Similarly, the gathering of satisfaction information from medical providers in the primary care practice, clinic staff, and referral agencies can provide feedback to behavioral health professionals about the quality and acceptability of services being provided. Consumer satisfaction with behavioral health in the primary care clinic is paramount to the overall success of integrated behavioral healthcare. Collecting information, initially on a quarterly basis, can also provide valuable feedback about the need for potential changes in practices and can help identify concerns that need to be addressed. We have found it most effective to keep the number of rating items as brief as possible with an opportunity for open-ended comments at the end of the rating form.

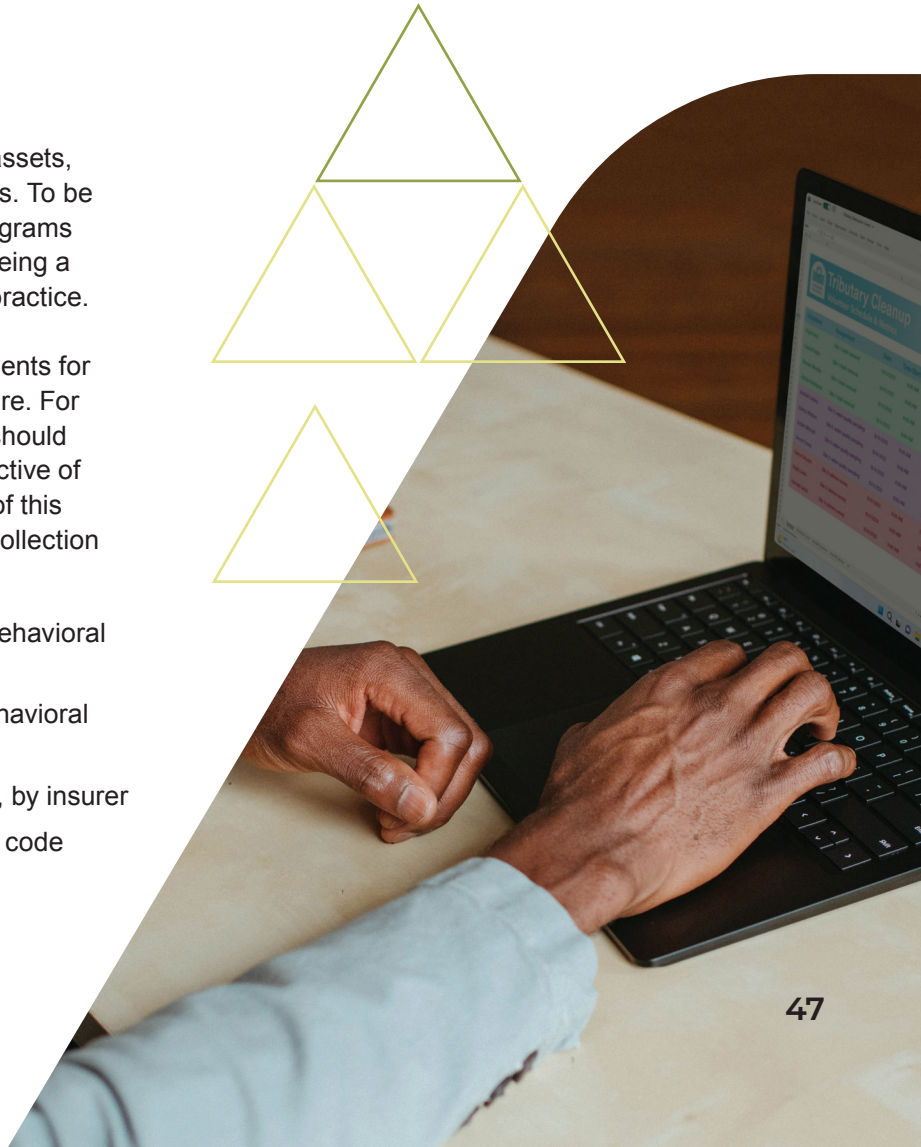
IPC Cost Analysis

Increasingly, healthcare is a business with assets, debits, income, expenses, and profit margins. To be successful, integrated behavioral health programs need to be viewed as value-added versus being a drain on the resources of the primary care practice. In the next chapter on business models, we discuss several types of business arrangements for integrating behavioral health into primary care. For pilot demonstration project purposes, data should be gathered on economic variables, irrespective of whatever business model is chosen. Much of this information is available through billing and collection activities. These measures include:

- Number of patients seen, by month, by behavioral health clinician
- Services provided, by billing code, by behavioral health provider
- Average service charges, by billing code, by insurer
- Average collections, by insurer, by billing code
- Number and percent of “no-shows” and cancellations
- Behavioral health income revenues, by collections versus bills filed

Economic Impact of IPC

More difficult to collect is medical cost offset information about the impact of integrated behavioral health services upon the primary care providers’ revenue-generating practices. If data can be gathered, an examination of the numbers of the clinic’s scheduled patients and revenues generated, before versus after the introduction of integrated behavioral healthcare, can demonstrate additional value to the practice. Data from a University of Michigan quality improvement project indicated that pediatricians were 15 percent to 20 percent more productive with RVU-generation when behavioral health services were made available within their primary care clinics. Recalling the study by Gouge, Polaha, et al. (2016), economic data showed that a primary care practice



Data from a University of Michigan quality improvement project indicated that pediatricians were 15 percent to 20 percent more productive with RVU-generation when behavioral health services were made available within their primary care clinics.

with five medical providers (three physicians and two nurse practitioners) billed an average of $1,142 more on days when a behavioral health professional was present in the clinic as compared to those days without behavioral health supports.

Collection of the following data, gathered before and after the introduction of integrated services, when possible, is recommended for comparison to demonstrate the net economic benefits to the primary care practice. The income column includes revenue generated by the clinic primary care providers and behavioral health clinicians. The debit column includes any start-up costs incurred when behavioral health integration was introduced. Specific measures that can be beneficial include:

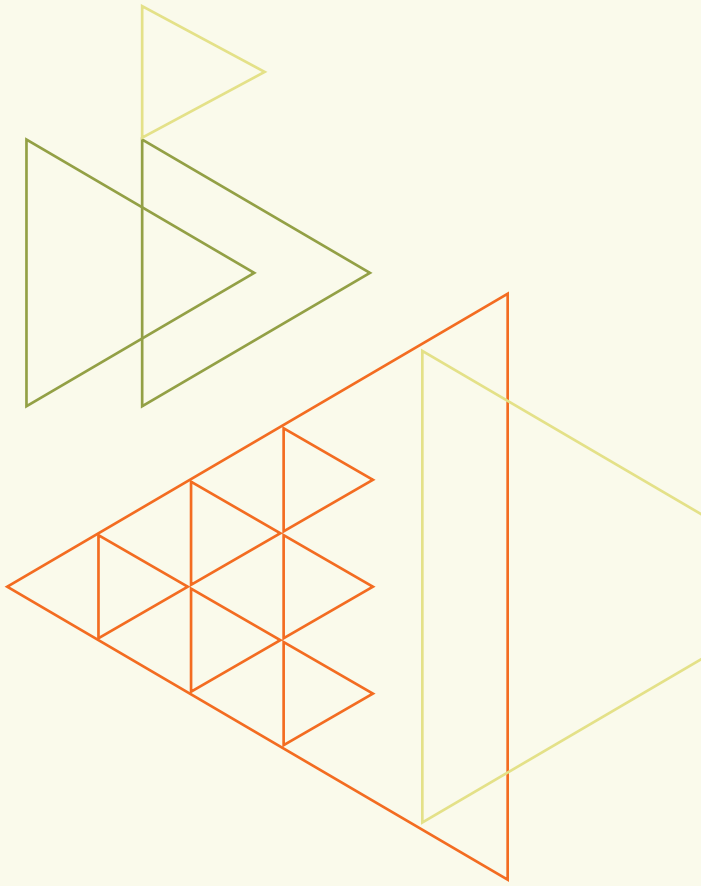
- RVUs or billings of physicians in the primary care practice—before and after integrating behavioral health services
- Numbers of clinic referrals to hospital emergency room department for risk assessments prior to and after integration
- Numbers of in-house risk assessments conducted by behavioral health clinicians and PCPs.
- Number and type of prescriptions for psychotropic medications before and after integration
- Number of sessions requiring extended physician time (fifteen minutes or more)
- Number of patients presenting with behavioral issues as primary reason for services

Conclusion

Successful behavioral health integration teams are often viewed as value-added by primary care providers and practices. On the other hand, when ambivalence is detected by key members of the primary care practice, (e.g., office managers, primary care providers, administrators), demonstrating the value of behavioral health integration in primary care is important to gain acceptance and support the sustainability of the integrated primary care partnership. Supportive data collection is often easily obtained and provides a demonstration of the importance of behavioral health to primary care practices. Supportive data collection can take multiple forms and may include organizational assessments, number of patients referred and treated by the behavioral health provider, patient and provider satisfaction, and a variety of indicators related to the economic impact and efficiency of the primary care team.

Tips and Take-Home Points

- The first year of behavioral integration into primary care will generally serve as a “test case” or “pilot program” that will determine the acceptability, cost efficiency, and sustainability of the IPC in the clinic.
- The collection of information on number of patients referred for behavioral health services, types of referrals, wait times, and show rates for scheduled behavioral health sessions can easily be collected from administrative records to reflect program utilization.
- Consumer satisfaction measures from patients, primary care providers, and clinic staff should be collected at least one time per year to provide feedback for the primary care behavioral health provider and to reflect effectiveness.
- Economic data reflecting medical cost offsets of increased time for medical providers and increases in physician revenues (or RVUs) should be collected and compared to earlier years.
- Self-supporting revenues generated by behavioral health clinicians should be gathered to demonstrate cost-efficiency and value of the integrated behavioral health clinician and program to the practice.



Chapter 5

Business Models of Integrated Primary Care

There are numerous variations of business models supporting integrated primary care (IPC).

In this chapter we discuss some of these business models that have been found to be successful. While there may be other methods for financing integrated services, our approach focuses on five business strategies that have been implemented. Some strategies are more applicable to large organizations in which there are several primary care practices owned by a healthcare system. Other strategies may be more efficient for small, physician-owned, or rural practices that are independent or are part of a locally managed small group practice of several clinics. It is important to keep in mind that business arrangements and models can change over time for a variety of reasons. For instance, one pediatric practice initially contracted with a behavioral health provider but later added her to the practice as an employee and then as a partner. Overall, it is important to view business models as flexible and modifiable.

Keep in mind that primary care practices are businesses and need to operate within fiscal constraints often dictated by health insurance companies, health system managers, and Medicaid/Medicare.

It is equally important to keep in mind that primary care practices are businesses and need to operate within fiscal constraints often dictated by health insurance companies, health system managers, and Medicaid/Medicare. If individual physicians and primary care practice organizations view having behavioral health practitioners as a potential financial drain, then probabilities for introducing and sustaining successful integration are limited. For this reason, we encourage behavioral health professionals to emphasize that IPC not only provides improved access to services for patients but is also value-added for the overall practice. Toward this end, it is important to demonstrate to clinic leadership that behavioral healthcare can ultimately be economically beneficial to the practice. Freeing up medical providers' time, providing risk assessment for patients within the practice, reducing hospital emergency department referrals, and handling problem phone calls from troubled parents and patients are but a few of the ways behavioral health providers add value to the overall functioning of the primary care practice environment.

It is necessary to point out to primary care providers that the integration of behavioral health professionals into their practices differs significantly from specialty care. Many practices, particularly in rural clinics and hospitals, have visiting healthcare specialists (cardiologists, surgeons, neurologists, etc.) who contract for separate space and utilize a substantial number of supports including

nurses, lab personnel, schedulers, operating rooms, examination rooms, etc. By contrast, in the Primary Care Behavioral Health model, behavioral health providers are integrated into the practice and work in collaboration with physicians, nurse practitioners, physician assistants, and staff. As noted earlier, patients are often seen within the practice in clinic exam rooms (often those available on physicians' days off). Behavioral health providers are integrated into the patient flow within the practice, available for accepting warm handoffs for patients in immediate need, assisting with handling behavioral disruptions, and providing immediate consultation on behavioral issues to physicians and other healthcare practitioners within the primary care clinic.

Often, with good intentions, clinic mangers try to identify private spaces or remote areas for behavioral health professionals to see patients. This typically removes behavioral health providers from contact with physicians and opportunities for consultation, assessment, relationship building, and taking warm handoffs and referrals. It is paramount for successful integration that behavioral health personnel see patients in spaces that are immediately adjacent to or within the same clinic space used by physicians and related healthcare providers. This allows physicians to involve behavioral health providers in sessions in which there might be a newly identified behavioral problem. Conversely, proximity allows behavioral health professionals to involve physicians in sessions where there is a physical condition (such as epilepsy, diabetes, cardiac condition, cystic fibrosis, etc.) that may be causing uncontrolled stress, anxiety, or depression or has been treated unsuccessfully with medications. Proximity also allows patients to observe the interconnectedness of physical and behavioral health professionals and can reduce the stigma often associated with behavioral services. Considerations for space and location for behavioral health sessions should be built into any agreement or contract between a behavioral health provider and primary care clinic.

The following are five different business models that can be used in an integrated primary care clinic along with other business considerations including licensure, professional liability insurance, paneling, and site certification.

Employment by the Primary Care Clinic

In this business arrangement, behavioral health providers are employed as part of the staff of the primary care clinic. This option is frequently used by large healthcare systems with multiple primary care clinic practices. In this arrangement, the provider becomes part of the employed staff with administrative supervision generally coming from a lead physician or clinic manager. Employment has significant advantages, including:

- A consistent and predictable salary
- Healthcare insurance and other employee benefits
- Authorizations, billing, and collections provided by staff of the clinic or healthcare system

- Little to no overhead expenses to the clinician
- Ease of entry into patient records from a single clinic electronic health record

Similar to most employment situations, there are both pros and cons in this business option. On the positive side, employment by the clinic or health system is most fitting for behavioral health providers who enjoy working as part of a team headed up by medical providers, who economically function best with a consistent paycheck, whose goals are primarily geared toward patient care (versus teaching or research), and who prefer to have administrative tasks handled by others. Specifically, cons include workloads determined by managers or other healthcare professionals not familiar with behavioral health services, salaries that may not be related to patient volumes or revenue generated by the behavioral health clinician, and lack of control over scheduling and types of patients seen.

Independent Behavioral Health Practice

For behavioral health providers who value independence and control over work parameters, an independent business arrangement may be most appropriate. This type of arrangement involves the independent behavioral health provider renting space within the primary care clinic. Independent practices are often found in small or rural private primary care practices and, initially, can be beneficial in "breaking into" a primary care practice since the commitment of clinic resources and potential costs is minimal. In this type of business option, behavioral health providers are responsible for becoming paneled with insurance carriers and developing systems to complete insurance authorizations, scheduling, billing, and collections. The provider may choose to work part-time or full-time in the primary care practice. This arrangement is inviting for individuals who wish to work part-time and have other sources for benefits such as healthcare insurance, retirement, etc. Specific advantages include a direct relationship between clinical productivity and earnings, opportunities for collaborations with healthcare providers as partners (versus employee status), and a significant level of control over administrative and clinical decisions. Additionally, independent providers require minimal administrative supports from primary care clinic staff, usually involving only reception and the gathering of patient insurance information.

Limitations of the independent model for behavioral health providers include a lack of employee benefits; start-up costs for expenses such as computers; creation of forms, handouts, test materials, etc.; delays in payment from insurance companies and Medicaid/Medicare; loss of income for vacations, non-reimbursable patient "no-shows" or cancellations; and "space rental" costs consistent with the Stark Act, which requires rental payment for space within the clinic at "fair market value." Fortunately, behavioral health providers require limited space. We encourage the use of clinic examination rooms—typically 80 to 90 square feet—for delivering behavioral healthcare, which are roughly the same size as most primary care patient rooms.

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Contractual Behavioral Health Services

A third business option for behavioral health providers in integrated care involves creating a contract between the behavioral health provider and the primary care clinic or healthcare system for space and administrative supports such as reception, billing, authorizations, computer access, electronic health records, and collections. In the contractual model, the behavioral health provider agrees to pay either a set fee or a percentage of collections to the primary care practice through a contractual arrangement. In this scenario, administrative supports are provided.

Income for a behavioral health provider is determined by the patient services billing revenue generated by the provider minus contractual expenses (e.g., administrative supports and space rental). For individuals with limited administrative experience or interest, and for part-time clinicians, the contractual business model is an inviting option. Although in our experience, primary care administrative overhead requirements (e.g., nurses, billing, coders, lab tests, medical equipment, utilities, rent, etc.) are more than 50 percent of collected revenue, behavioral health practice costs are significantly lower. We have seen successful practices pay anywhere from 20 percent to 35 percent of collections to their primary care practice partners. With a patient load of twenty-five to forty sessions per week—as compared to three typical physicians' more than four hundred sessions weekly—the addition of administrative supports for behavioral health is minimal. Educating administrators and staff on the differences between primary care medical sessions versus behavioral health sessions and billing procedures is recommended, as they are generally unaccustomed to the levels of supports required for behavioral providers and reimbursement procedures. It is common for primary care administration and staff to become concerned with the resources they are accustomed to providing to a primary care provider. Initially, it may take some time for clinic staff to learn the billing systems for behavioral health, which may be combined into overall insurance and Medicaid reimbursement or could be a separate billing system, depending on the state and insurer. It is helpful to provide the administrative team with a list of the most commonly used behavioral health CPT codes. Chapter 10 in this manual provides a short list of behavioral health codes that may assist billing staff.

Limitations of this type of contractual business arrangement include lack of health insurance, paid vacation, and retirement funding, as well as increased self-employment taxation (15.3 percent versus 7.65 percent for FICA). Contractual arrangements and percentages are typically renegotiated over time, and contracts may stipulate specific days and times of service. These obstacles can be overcome with a well-designed contract. We have included a sample contract in the supplemental guide that can provide a model for use in negotiations. This type of contractual arrangement can be beneficial as a "demonstration project" for an initial one-year period, which can then be used to assess the effectiveness and economic feasibility of integrated primary care.

Integrated Primary Care Agency Contracts with Primary Care Practices

A fourth business model of IPC involves contractual agreements between a behavioral health agency and a primary care medical practice. In an agency contract model, practitioners are hired by a sponsoring behavioral health agency but are assigned clinical responsibilities within a primary care practice under a contractual arrangement. The contracting behavioral health agency takes responsibility for supports, including insurance paneling, authorizations, billings, electronic health records, collections, space rental, etc. Behavioral health professionals are hired by the contracting agency as employees or as contracted providers. There are significant advantages for the agency contract approach for primary care practices, as well as for behavioral health professionals. Specifically, administrative supports required of the contracting primary care practices are minimal. Administrative tasks such as billing and collections for behavioral services are left to the contracting behavioral health agency, which may be more skilled and experienced in dealing with behavioral health insurance issues. Another advantage is that the contracting agency takes on the responsibility to ensure continuity of care when there is an inevitable

change in staff, parental leave, extended sickness, etc. For the behavioral health practitioner, having access to benefits is a major advantage as well as having access to colleagues from the home office staff.

There are, of course, disadvantages to agency contract arrangements. For one, there may be dual electronic health record (EHR) systems that require duplication of patient reports by the behavioral health provider to satisfy the requirements of both agencies (e.g., ensuring session notes are in both EHRs, accessing both for information on a patient, maintaining two scheduling systems, etc.). Being remotely placed away from the home agency may also provide some sense of isolation and conflicting allegiances. Requirements of two separate health systems may also create conflict for the behavioral health provider who may be required to meet standards for separate agencies in terms of required training, human resource policies for vacations, sick leave, reporting requirements, and timelines, etc. With time and communication between the two contracting agencies, it is possible to minimize these challenges. Often, more efficient ways of integrating systems evolve over time and experience in the practice. The Munroe-Meyer Institute Psychology Program at the University of Nebraska Medical Center has used this approach successfully with the goal of gradual independence or employment for behavioral health practitioners within contracted primary care practices.

In an agency contract model, practitioners are hired by a sponsoring behavioral health agency but are assigned clinical responsibilities within a primary care practice under a contractual arrangement.

Circuit Rider Model

Often, especially in rural areas, a primary care practice may be staffed with a single physician or nurse practitioner. In other rural clinics, there may be a primary care itinerant, or visiting, medical provider who travels to multiple clinics, providing healthcare one to two days per week at each site. The patient population served in either of these arrangements may not be extensive enough to feasibly support a behavioral health clinician. We have found this true particularly in rural areas where a PCP serves the population of a small town and surrounding communities. While rural behavioral health needs are consistent with urban patient populations, the total patient population for a single practice may not warrant full-time behavioral health service delivery. Additionally, family practices are more prevalent compared to pediatric-only practices in rural areas. Therefore, even if there are two or three primary care medical providers in a practice, these clinics typically have smaller percentage of pediatric patients. In these cases, just as with church clergy in the 1800s who served the needs of many small towns and villages by creating a "circuit" of services held on a rotating basis, a behavioral health clinician might also serve the needs of several communities. In one of our earliest rural explorations, the behavioral health practitioner spent two days in a larger community (population 5,000), one day per week in a moderately sized community (population 1,500) and one day every other week in two smaller communities (with populations of 800 and 900). Any of the four business models (*Employment by the Primary Care Clinic, Independent Behavioral Health Practice, Contractual, or IBH Agency Contract*) presented earlier could be applied within each of the various primary care practices involved in the behavioral health circuit of primary care practices.

Additional Business Considerations

Professional Licensure

This section is written for newly graduated professionals entering the field of behavioral health service provision. This information will be repetitious for anyone who has already gone through the licensing process. In some states, graduation from a training program that is approved by a national professional organization (American Psychological Association, American Counseling Association,

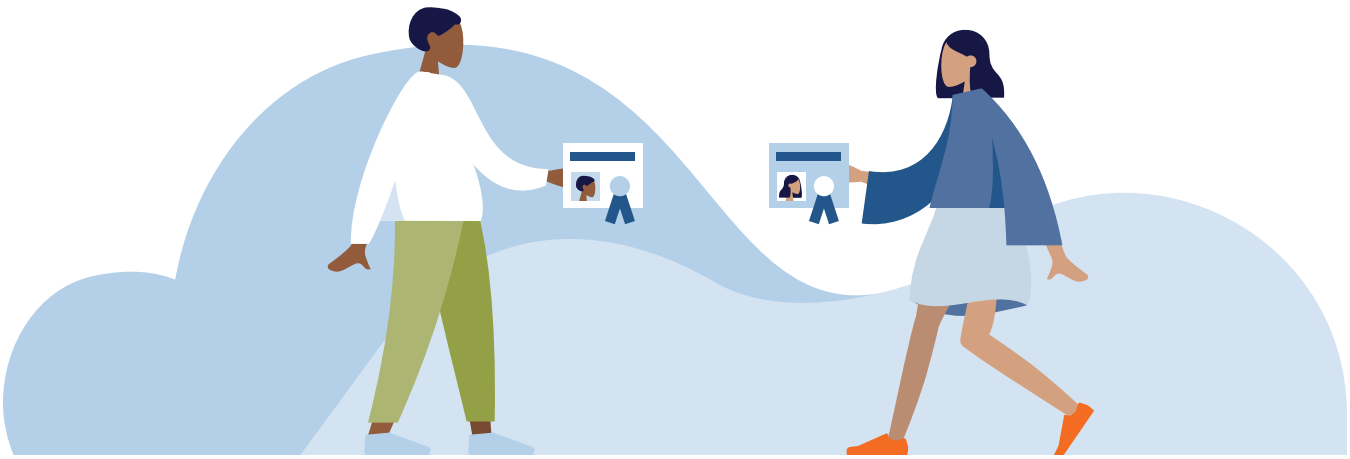
American Association of Marriage and Family Therapists, Association of Certified Social Workers) can greatly speed up the process toward licensure. If a behavioral health professional has graduated from a nonaccredited training program, state licensure boards will generally request proof that the training program had coursework equivalent to that required of a professional organization's approved training programs.

In addition to verification of academic and clinical training, most states also require passing a written examination demonstrating knowledge in a particular field of behavioral health. In psychology, for example, a passing score on the EPPP national examination is most often required, whether an individual has graduated from an accredited or nonaccredited training program. Other examinations are sponsored by national professional groups for social work, marriage and family therapy, and counseling. An increasing number of state licensing boards are also now requiring the passage of an oral examination conducted by a panel of licensed professionals selected by the state licensing agency.

Finally, many states require that graduates receive supervision by a licensed behavioral health professional prior to granting full licensure. Supervised practice can range from two thousand to three thousand hours, during which the provider may be provisionally licensed. Licensing boards have specific criteria for the number of hours of supervision and direct client contact comprising the postgraduate experience. Some states have eliminated postdoctoral supervision requirements for psychologists, but this again varies from state to state. For individuals who are from nonaccredited programs, some licensure boards may require further documentation of course content to ensure that academic preparation meets standards and is comparable to requirements of accredited programs. Licensing boards may even require copies of course syllabi or course descriptions taken from graduate catalogs. Obtaining information from one's state licensing board can answer many questions related to licensure. Applicants should be aware that the licensure process can often take months, and we encourage taking the national behavioral health examination as soon as possible to facilitate the process.

Paneling/Credentialing with Health Insurers and Healthcare Organizations

For commercial health insurance companies and Medicaid/Medicare to recognize a behavioral health professional as qualified to receive payment for providing behavioral health services, it is necessary to become "paneled" as a licensed and eligible provider with each insurer. In order to become a member on an insurance company's panel of approved providers, one must go through a credentialing process to verify professional qualifications to provide care. Credentialing generally involves submission of licensure, professional credentials, location of practice, and a background check in order to ensure that one meets standards for service delivery. Other requested information may include work history, internship, clinical practicums, references, etc. (It is important to note that behavioral health provider



titles vary from state to state and may include labels such as provisional psychologist, licensed psychologist, clinical social worker, licensed mental health professional, clinical social worker, licensed professional counselor, etc.). Behavioral health providers need to investigate titles and requirements for the state(s) in which they plan to practice.

An application to become a paneled member needs to be completed for public or private insurers. It is important to determine which insurance companies you wish to become a paneled member of. Some practices may serve patient populations with as many as ten to twelve different insurance companies, each requiring an application for paneling. Many insurance companies will only panel behavioral health providers who have already attained full licensure. For states that have provisional licensure status for newly graduated providers under supervision, individuals with these credentials may be able to bill select insurers. (For example, in Nebraska, provisionally licensed practitioners can bill Medicaid and some Blue Cross Blue Shield products.) In some states, behavioral health graduates under supervision are allowed to provide services but must bill under their respective supervisors. A few states have instituted a universal credentialing application process that is common to most insurers, and this reduces unnecessary replication of information for paneling across health insurance providers.

A major advantage of working with a large multisite primary care medical clinic or healthcare system is that there are usually administrative staff within the practice who are familiar with the credentialing and paneling procedures in your state and have contacts with insurers. Much of the information being requested by various insurance companies is similar, and administrative staff can assist in completing application forms for credentialing and paneling. In some cases, the credentialing expert within the practice will simply provide the forms that need to be completed while, in other instances, administrative staff members will gather information from the behavioral health provider and complete forms for him or her, only requiring signatures. It is important to consider that the credentialing and paneling process can take several weeks to several months for insurance companies to complete. Allowing three to four months lead time should be an expectation.

Professional Liability Insurance

Professional liability coverage, sometimes called malpractice insurance, protects the primary care practice from potential errors or omissions made by any of its licensed providers. Primary care practices generally require that all healthcare providers maintain professional liability insurance. In those cases where a behavioral health provider is hired by the practice and becomes an employee, the practice may have a group plan covering all employees, and the behavioral health provider can be added to this group plan. In the case of independent practice or contractual agreements with medical practices, a behavioral health provider will be required to maintain his or her own professional liability insurance. Coverage can usually be purchased from one's professional organization. For example, professional liability insurance can be purchased from plans offered through the American Psychological Association, the American Counseling Association, etc.

Professional liability coverage, sometimes called malpractice insurance, protects the primary care practice from potential errors or omissions made by any of its licensed providers.

If a behavioral health provider is employed by another agency that is contracting with the primary care practice, the behavioral health employee can generally be covered by the group plan of the employing agency. Copies of professional liability insurance policies can be obtained directly from the insurance company or from the administrator of the group plan within the practice or healthcare system. Policies cover legal actions brought against a practitioner but also support defense of practitioners if complaints against them are filed with licensing boards or professional organizations. Although coverage may be provided as

part of an overall group plan, we strongly encourage practitioners to also maintain their own professional liability policies. Group plans generally tend to cover the practice, while an individual policy specifically covers the individual practitioner.

Credentialing and Paneling

Many terms utilized by insurance companies can be confusing. When starting a behavioral health practice, completion of credentialing and paneling are important processes required by health insurance companies in order to begin filing claims for services.

Credentialing is the process used by insurance companies to verify education, training, professional experience, and licensure to determine whether one meets the criteria for serving as a provider in the insurer's network panel.

Being **paneled** indicates that one is listed as a preferred provider for an insurance company, having met specific credentialing requirements for one's level of training, degree, and licensure. Each insurance company, including Medicaid and Medicare, has its own process of credentialing to become a paneled member of its network of providers.

Site Certification/Credentialing

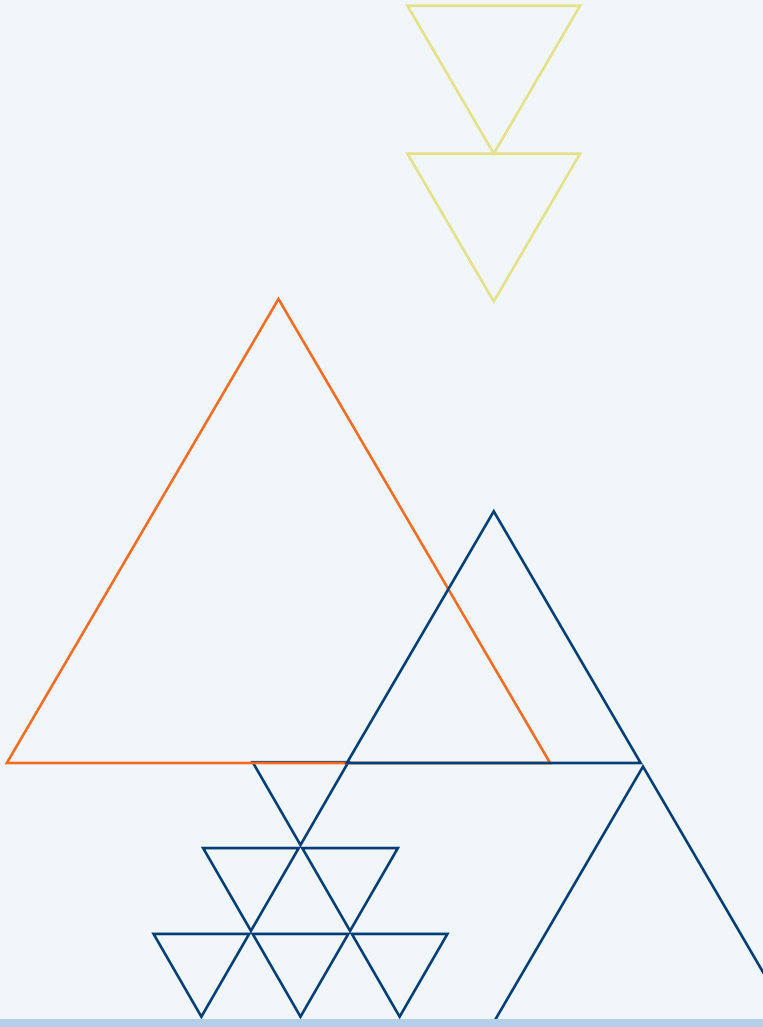
Some insurers and Medicaid/Medicare not only require individual practitioners to be credentialed and paneled, but also require that the practice site be certified. In earlier days when behavioral healthcare was independent from medical practices, two forms of site credentialing were common. The medical practice had its own certification, while behavioral health was viewed separately and had its own site credentialing. With the advent of the integration of physical and mental health practices, this has become less of an issue, and behavioral healthcare can be part of the overall site certification. Again, this may vary from state to state, and administrative personnel of the primary care practice can facilitate any needed applications or additions to current site certification requirements. In order to qualify for insurance reimbursement for behavioral services, it will be necessary to ensure that the site has met all credentialing requirements.

Behavioral Health Staffing Ratios

There is no set standard for behavioral health personnel staffing in primary care. Robinson and Reiter (2016) report a staffing ratio of one behavioral health provider per 3,500 patients, which is the guideline used by the United States Air Force. If the need for behavioral health services exceeds capacity, then a clinic may hire or contract for additional providers or extend the number of patients a provider can see. In our experience, delivering behavioral health services to pediatric patients involves not only the child or adolescent, but also his or her family. Because of the additional time required to educate parents to change their own behavior in dealing with their child's emotional and behavior problems, we suggest a lower behavioral health staff to patient ratio. In larger pediatric practices involving multiple physicians, nurse practitioners, and PAs, having additional behavioral clinicians will be necessary for optimal effectiveness. This can be measured by wait times for appointments. When the behavioral health clinician is seeing more than thirty patients per week and wait time for appointments exceeds three to four weeks, staffing ratios and numbers of treatment sessions per patient should be reviewed.

Tips and Take-Home Points

- Integrated behavioral healthcare can be economically supported using various business models.
- Successful business applications include employment of the behavioral health provider, independent behavioral health practice, contract to a behavioral health provider for services, contract with an established behavioral health agency, or multiple contracts with smaller primary care practices.
- Business necessities for the behavioral health clinician to work in a primary care practice involve professional licensure, paneling with healthcare insurers and Medicaid/Medicare, professional liability insurance, and site certification.
- While there is no established standard for IPC staffing, there is an established ratio used by the Veterans Administration one behavioral health provider for 3,500 patients. We suggest a somewhat lower rate for pediatric practices.



Chapter 6

Integrated Primary Care—Implementation and Operations

There are two major ways to implement changes into an existing IPC system.

There are many major ways to implement programmatic changes into an existing primary care system. One approach involves significant planning, meetings, reviewing existing literature, creating teams, ensuring representation from all parties involved, designing job descriptions, hiring and training staff, projecting budgets and revenues, etc. One university hospital, by way of example, had planning meetings for two and a half years before finally implementing a change strategy. Twelve primary care clinics were identified, and three clinicians hired. Every clinic was assigned .25 FTE of a behavioral health provider. Each behavioral health clinician was expected to cover four clinics. Hired behavioral health staff members were all licensed and experienced in traditional behavioral health provision (representing counseling, social work, and psychology). Staff were provided with no training in best practices for behavioral health application in primary care medical settings. Within nine months, two of the three licensed practitioners left the institution for other positions. This fairly common approach to implementing integrated behavioral health into primary care typically involves a committee of leaders from within the healthcare system. The leadership team is tasked to implement an integrated primary care strategy and may include nurse administrators, business managers, clinicians with traditional behavioral/mental health training, or physicians involved in primary care practice, all of whom lack experience in IPC.

An alternative, and more successful approach to IPC program implementation involves employing a consultant with expertise and experience in IPC to:

- assess readiness of primary care practices for integration
- assist in recruiting clinicians who are best suited for integrated practice
- develop operational pathways
- train staff in brief interventions
- assist in designing program evaluation strategies

This approach can lead to a much quicker and effective program introduction and reflects recommendations from the field of implementation science (Fixsen et al., 2005, 2009). In addition to additional program implementation, ongoing consultation and fidelity reviews of the program from experienced professionals can also ensure the sustainability and maintenance of quality programing.

This chapter focuses on logistical considerations and recommendations for integrating behavioral healthcare in a primary care medical setting. Some topics may be repetitious from earlier chapters but are included due to their paramount importance for successful IPC clinic functioning. Operational topics presented in this chapter are derived from the literature on integrated care practice and our experiences with administrators, primary care physicians, nurse practitioners, physician assistants, support staff, and behavioral health professionals themselves. Suggestions are made to assist clinicians in addressing those administrative and procedural problems typically encountered in the development of an IPC clinic.

Professional Liability Insurance

As noted earlier, to protect oneself and the primary care clinic in which services are to be offered, professional liability insurance is usually a requirement for provision of behavioral healthcare. Policies are available for licensed behavioral health providers from professional organizations such as the American Psychological Association, National Association of Social Workers, American Counseling Association, etc. Copies of insurance coverage should be provided to the primary care clinic manager or health system administrator and is often included as a requirement in contractual language. Our behavioral health clinicians typically take out coverage at the $1,000,000 per episode and $3,000,000 total levels.

Space Utilization

The ultimate goal of integrated behavioral healthcare is to coordinate primary medical and behavioral health services to provide patient healthcare most effectively. It is recommended that, to the greatest degree possible, behavioral, and medical primary care providers utilize the same clinic space to achieve optimal integration. This is ordinarily accomplished by the behavioral health provider practicing in exam rooms typically utilized for primary care visits. (Physicians in a primary care practice may have a day off during the week, and these exam rooms can be reserved for the behavioral health clinician). In the case that there are no clinic rooms available, each of the physicians in the clinic may “donate” one of their exam rooms for a day a week. This may mean changing clinic rooms according to availability. A less desirable but acceptable option is for a separate behavioral health clinic space to be situated near physician and patient flow areas.

While there is no one universal solution for clinic space, the main concept for successful integrated primary care is collaborative access to patients by medical and behavioral providers.

Each primary care clinic is unique in its physical layout, staffing, and space allocation. While there is no one universal solution for clinic space, the main concept for successful integrated primary care is collaborative access to patients by medical and behavioral providers. The ideal clinic configuration is one in which an allocated space for behavioral health is readily accessible to patient flow. In one of our established IPC clinics with three healthcare providers, an offer was made for an additional physician to join the practice, thus utilizing all available clinic space full-time for physical healthcare. The clinic offered to provide space in a separate office area across the hall, which was totally separated from the clinical practice. In this case, the clinic was informed that we would be unable to continue providing behavioral health services under those circumstances given the nature of the integrated care approach. Consequently, a compromise was made whereby behavioral health would remain in the practice using

"donated" clinic exam rooms on a rotational basis. The point to be made, however, is that, in order for the primary care practice to achieve integration, behavioral health has to be positioned as an ongoing and integral part of the primary care clinical operation.

Reception and Scheduling

One of the few administrative requirements for IPC is support from the front office staff. In a typical small, three-physician primary care practice, front office staff receive and schedule seventy-five to one hundred patient visits each day. By contrast, a behavioral health provider may require reception and scheduling for an average of eight to twelve patients per day. Depending upon the business model established, reception duties may involve scheduling sessions, checking patients in, and gathering insurance information. In other business models, office staff may need to enter patient data into the clinic's electronic health record, billing system, and scheduling program. Overall, behavioral health reception and scheduling duties should represent less than 10 percent of the front office workload. Nominating a lead or point person among front office staff to provide or manage these duties and any changes with procedures, insurance coverages, scheduling, etc., can be quite helpful.

Electronic Health Records

The integration of physical and behavioral healthcare for patients requires collaboration between medical and behavioral healthcare providers for optimal patient care. Many physical conditions have co-occurring behavioral health concerns, and treatment may involve both medical and behavioral health interventions. For example, national estimates indicate that one in four children with epilepsy also have depression or anxiety (LaGrant et al., 2020). Conversely, many behavioral health disorders have co-varying physical concerns. Recent research has indicated, for example, that individuals with severe mental illness have a lifespan of seven to twenty-four years less than national

expectation averages (Chesney et al., 2014). With children and adolescents, healthcare conditions such as ADHD, anxiety, pain management, obesity, sleep disorders, elimination disorders, etc., may require a combination of medical and behavioral treatments.

For primary care practices to be a "medical home" for patients, a single health record involving both medical and behavioral diagnoses, treatment planning, and progress needs to be implemented. There are multiple ways to achieve this integration depending on the business model utilized, and there are significant advantages to having a common patient record. Evaluation of behavioral side effects of some psychotropic medications, for example, can best be conducted by psychologists who are trained in behavioral assessment. Consequently, patients coming into the practice on varying dosage levels of prescriptions can have their medications adjusted based upon data evaluated by the clinic's behavioral health professionals. Suicidal risk assessment, evaluation for developmental disorders, learning disabilities, autism, and drug dependency are all areas in which collaboration and joint teamwork are best suited to meet patient needs. Documentation of collaborative primary care provider and behavioral health clinician efforts needs to occur in a single electronic health record.

For primary care practices to be a "medical home" for patients, a single health record involving both medical and behavioral diagnoses, treatment planning, and progress needs to be implemented.

There are many vendors and electronic health record (EHR) formats used in medical healthcare, and each may require the behavioral health provider to adapt to whatever system is currently being used in the primary care practice (many of which were never designed to include behavioral health information). Documentation of all sessions should be placed into the electronic health record for both physician information, as well as for insurance reimbursement purposes. It is also recommended that, for warm handoffs and emergency referrals, a verbal report or brief note be provided to the physician on the same day as the referral.

The creation and maintenance of a common EHR is a decision that will need to be discussed between the primary care practice and behavioral health provider. In many behavioral health graduate programs, trainees are educated to restrict to behavioral health records. Some of the initial failures of IPC occurred due to the reluctance of psychologists to share information in the patient record (Cummings et al., 1997). There can be security steps implemented to restrict access to a behavioral health provider's notes housed in the same electronic medical record (Brady et al., 2021). In a true integrated care practice, however, there is a common health record that is shared with all providers serving a patient. If necessary, restrictions can be placed upon access to the most sensitive information. However, in our experience, primary care providers need to have access to the behavioral diagnostic and treatment reports of their patients, and conversely, behavioral health providers frequently need access to the medical record regarding physical conditions that may be impacting patients' behavioral health issues. This can be a significant shift in practice for behavioral health providers who have traditionally been trained to restrict all access to behavioral health patient information.

Finally, an operational question to ask of the clinic staff involves whether there is a system in place for chart reviews. To maintain compliance with insurance company requirements for diagnosis, appropriate billing codes, session documentation, and billing procedures, many healthcare practices have monthly or quarterly reviews of samples of patient records. This process is designed to provide feedback to clinicians and to ensure that documentation meets reporting standards. To the greatest degree possible, the quality of behavioral health reports should mirror those standards of the primary care practice. It can also be beneficial to have an external behavioral health colleague occasionally review a sample of the behavioral health clinician's electronic health record entries. For behavioral clinicians employed

by an outside agency but contracted to the primary care practice, this can be challenging, as two separate sets of electronic health record standards may be imposed.

Outside Referrals

When starting a new IPC clinic, it is advisable to discuss with the leadership of the clinic how to manage referrals from medical providers or agencies outside of the practice. Integrated primary care involves the capacity for medical staff to make referrals to behavioral health providers within the practice. Therefore, the decision to allow outside referrals should be carefully considered and discussed with the primary care team. Prioritizing services for patients referred by the primary care team should be a focus of the behavioral clinician, if possible. Accepting outside referrals may increase patient volume as the behavioral health practice is being built. Dissatisfaction from referral sources may be experienced, however, should the decision be made to no longer accept patient referrals from outside of the clinic.

In underserved inner-city and rural locations, the primary care behavioral health clinician may be the only provider in that area. In those instances, acceptance of patients from outside of the primary care practice should be discussed with the clinic team. Opening behavioral health services to patients from outside of the practice may be the only option for local families. Acceptance of referrals from outside of the primary care clinic can also be helpful as it advertises the availability of services to the local community. Referrals from schools, other medical practices, child welfare agencies, etc., can help build the caseload for the behavioral health professional. A secondary benefit for the primary care clinic is that patients satisfied with their integrated behavioral health services may also transfer their medical care to the primary care practice.

With the passage of time and increases in internal referrals from physicians, however, accommodations for providing behavioral health services to outside referrals may have to be limited. This also can be a rationale for increasing the numbers of behavioral health providers within the primary care clinic or

establishing another integrated care practice in a clinic whose primary care providers have consistently referred numerous patients. In fact, some new integrated care clinics have been established as a result of tracking the referrals from outside physicians. In our experience in pediatric primary care clinics, three to five physical healthcare providers (physicians, nurse practitioners, or physicians' assistants) can easily fill the schedule of one full-time behavioral health provider.

Insurance Plans

One of the considerations for the successful integration of behavioral health personnel into primary care is the mix of health insurance plans (and Medicaid/Medicare) supporting patients seen in the practice. Office staff will have a list of commercial health companies insuring patients in the primary care practice. Insurers require clinicians to become credentialed and paneled (see Chapter 5), and each company has its own fee reimbursement plan. It is typical that there are multiple healthcare insurers covering a primary care patient population, including Medicaid and Medicare. It can be helpful for behavioral health professionals to enroll in the major insurance panels prior to integrating services in order

to have more immediate access to patient referrals and to save time and effort.

Another reason to examine the mix of insurers within the primary care practice is to be able to examine reimbursement rates for behavioral health services. Reimbursement rates can vary significantly between insurers according to billing code, licensure status, session time, behavioral health profession, and degree (i.e., psychologist, psychiatrist, psychiatric nurse practitioner, social worker, counselor, or marriage and family therapist). Gathering information from each insurers' fee schedule provides the opportunity for behavioral health clinicians to project revenues needed to be economically viable within the practice. We have found that, in some underserved areas, particularly rural towns, there may be a large employer that provides health insurance coverage for the majority of patients served in the clinic. In these cases, some direct negotiations with insurance companies can potentially produce higher levels of reimbursement than published fee schedules due to the lack of providers in that geographic location.

Projected Revenue

In gathering fee structure information from insurance companies, clinicians should be able to project revenues generated by the IPC services. It is helpful to create a table of reimbursement rates, according to insurer, by billing code. Based upon the percentage of patients served various private insurers or Medicaid, it can then be possible to project expected reimbursement based upon numbers of patients seen, reimbursement rates of various insurance companies of patients served in the clinic, and percentages of patients covered by each insurance plan. This information can also be helpful in projecting income when in a contractual or independent provider arrangement or when employed and seeking a raise in salary. Built into any formula for projection of income will also be other factors, including no-show rates, canceled appointments, vacation time, holidays, and, in the case of a contractual business option, costs for billing services and clinic space rental. Unlike public community mental health centers that may typically have a 40 percent no-show rate, integrated behavioral health services provided in primary care practices generally have an 80 percent to 90 percent compliance rate in keeping appointments (Valleley et al., 2020).

We have found it helpful to use a forty-eight-week work schedule with an 85 percent "show rate" for patient services in projecting revenue generation. Another factor to be considered is the start-up delay

that usually occurs during the first three to six months of implementing an integrated care practice. Delays in getting full licensure, paneling with insurance companies, and time lag between billings submitted to insurers and reimbursement can sometimes require weeks to months. The good news is that this is a temporary situation, but it needs to be considered initially, just as starting any new business venture might require.

We highly recommend having a discussion on preferred communication style with physicians and other healthcare providers in the practice regarding behavioral health services provided for their patients in the primary care practice.

Methods of Communication

A major key to success in IPC is communication with physicians and other healthcare providers in the practice. We devote an entire chapter in this manual to relationship development (see Chapter 8). During initial negotiations and movement into the clinic, however, it may be beneficial to speak with physicians about their communication preferences. Specifically, some clinics conduct team meetings to discuss cases for the day or those with common presenting problems, while in other clinics, healthcare providers are so busy that meetings are difficult or impossible to schedule. Some practices conduct meetings over the lunch hour on a weekly basis. Still other practitioners prefer brief notes (outside of the electronic health record) advising them that the behavioral health practitioner has either scheduled an appointment, seen the patient, conducted an assessment, developed a treatment plan, is reporting progress, or is recommending referral to a more appropriate service. Notes need to be brief and to the point, and usually a paragraph will suffice for low-risk patients. A more detailed note may be warranted for higher risk cases (e.g., parents divorcing, suicidal ideation, etc.).

We highly recommend having a discussion on preferred communication style with physicians and other healthcare providers in the practice regarding behavioral health services provided for their patients in the primary care practice. Giving providers information on availability to take warm handoffs, consult with physicians, handle phone calls, meet with new patients, or help with referrals for more intense specialty care are all forms of communication that need to occur within the practice. We also suggest reserving five to fifteen minutes per hour during which doctors, nurses, and office staff can have access to a behavioral health provider's schedule. As discussed later, we additionally recommend being open to the session interruptions (much like primary care providers who are interrupted during patient care for ready consults or emergency referrals).

Behavioral Health Workload Expectations

In studies of physician caseloads, it has been found that primary care medical providers spend, on average, eight to twelve minutes in face-to-face contact with patients or families (Meadows et al., 2011). Other time is spent reviewing patient records, speaking with clinic nurses about presenting problems, reviewing lab results, etc. Overall, on average, primary care physicians see twenty-five to forty patients per day in their practices, which can average from eight to ten hours daily. Medical specialists, by contrast, spend significantly larger amounts of time with patients, see fewer patients per day, and deal with conditions that are not well suited for the fast pace and limited time available in primary care. It is important to set expectations for availability and services provided by a behavioral health provider. Workload studies have suggested that full-time behavioral health professionals provide approximately twenty-five to thirty hours of direct patient care delivery per week. This schedule allows time for reviewing patient records, writing reports, contacting schools, families, and social agencies, etc. The numbers of patients seen during this scheduled time

can vary significantly. Similarly, insurance companies have a wide variety of required time parameters and reimbursement rates for intake, assessment, and treatment services, and the behavioral health clinician will need to review these standards for each insurer. Typically, initial intakes and treatment planning sessions may require forty-five to fifty minutes, testing assessments may require one to two hours, and follow-up sessions may be scheduled for twenty-five to fifty minutes. This information needs to be shared with primary care providers in order to keep expectations for services realistic. Reserving part or all of one day per week to catch up on documentation, billing forms, continuing education, etc., at the primary care clinic can also be beneficial and helps ensure that the clinician does not become overwhelmed.

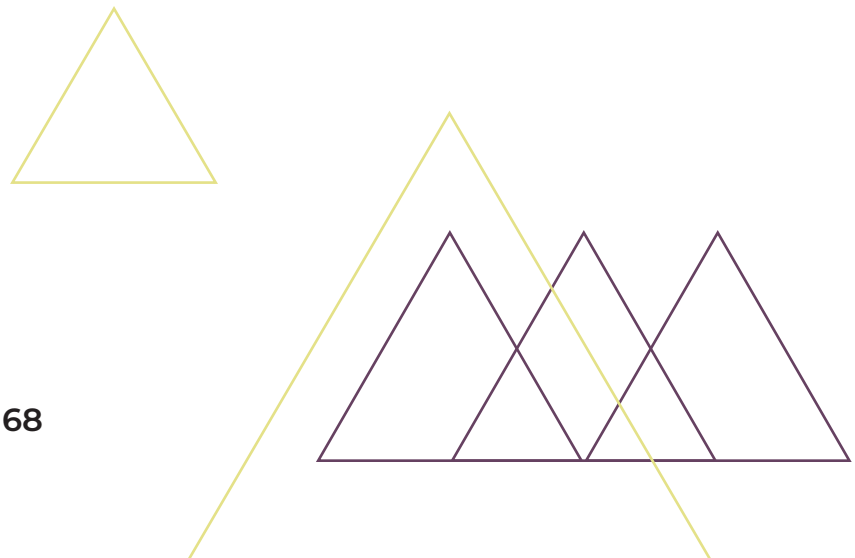
Referrals to Specialty Care

The Primary Care Behavioral Health (PCBH) model of integration emphasizes short-term interventions and a focus upon population health. Our experience in pediatric primary care suggests that a team of a well-trained behavioral health and physical health professionals can successfully screen, diagnose, and treat 85 percent to 90 percent of behavioral health disorders presenting in primary care. Additionally, behavioral health providers can assist medical providers in anticipatory guidance, parent education, interactions with schools, and other forms of prevention related to both medical and physical health issues.

Because of the brief therapy focus and the need to address behavioral issues for 20 percent of the pediatric patients served in a primary care practice, the behavioral health clinician should not be expected to provide intensive therapy for primary care patients with the most severe mental health disorders. Just as a primary care physician would make referral for surgeries, obstetrics, oncology, orthopedics, or chronic conditions (such as epilepsy, diabetes, or cystic fibrosis), the behavioral health clinician, along with the primary care team, should develop resources in the community or regional area that specialize in conditions requiring intensive and potentially long-term treatment. Some examples might include teens diagnosed with substance use disorders or eating disorders, or children diagnosed with autism spectrum disorders.

Logistics

Day-to-day operations in the pediatric primary care clinic are routine, and the addition of a behavioral health provider to the practice may require some minor adjustments. It can be helpful for the provider to develop a checklist of topics that will need to be addressed in the implementation phase of integrated behavioral health services into the daily operations. Items on the checklist can be covered with either the clinic manager or the lead physician. It is recommended that this process occur during the agreement to integrate behavioral health into the clinic. The following provides a list of some of the items that should be included in a logistics checklist that can be used in assessing readiness for integration of behavioral health into a clinic as well as providing an outline of clinician needs for consideration to the office manager.



Tips and Take-Home Points – Logistics Checklist

- Scheduling System: How are patients currently scheduled for appointments within the primary care clinic? Who does the scheduling? Can behavioral health appointments be added?
- Behavioral health Supplies and Location: Where could supplies for the behavioral health clinician be stored? These would include test kits, toys for younger children, handouts, screening measures, etc. Additionally, would there be access to supplies from the clinic (staplers, pens, paper, etc.)?
- Printers/Copiers: Are printers and copiers available within the practice for use by the behavioral health clinician? Is there a "code" needed to access printers/ fax machines?
- Internet Access: Does the clinic maintain its own information technology system or are the computers linked to a remote IT hub site? Can the behavioral health provider obtain access to the internet for emails, contacts with schools, discussions with parents, telehealth applications, etc.? If so, is there a protection system requiring a password?
- EHR Access: What electronic health record system is employed in the clinic? Can the behavioral health clinician get access to the EHR to enter diagnostic and treatment reports or to access medical information that may be relevant to behavioral health treatment (such as psychotropic medications, compliance with medication regimens, chronic conditions with co-occurring behavioral symptoms, etc.)? If not, there is a system for uploading behavioral health reports into the EHR?
- Check-In and Notification: Can front office staff check behavioral health patients in, obtain insurance information, provide "behavioral health screening measures" to new patients, and alert the behavioral clinician that patients are ready to be seen for their appointments?
- Physician Referral Process: Is there a desire for a formal referral procedure for specialty behavioral health services? If so, how is this done with other outside referrals from the clinic? How should physicians "triage" most needy patients in need of immediate behavioral health intervention?
- Confidentiality: Is there a clinic policy on confidentiality and does this need to be adapted to include behavioral health information? If necessary, is there a procedure in place to protect potentially sensitive behavioral information within the patient record?
- Informed Consent Documentation: Is there a current informed consent document that covers all services provided by the clinic? If not, can behavioral health be added to the consent form? For contractual behavioral health providers, is there a need to have an additional consent form for patients, or is the business agreement between the behavioral health clinician and the clinic sufficient?
- Student/Intern Participation: Behavioral health clinicians are often asked to supervise medical residents, interns, and/ or practicum students. Does the clinic allow these activities?
- Telephone Messages and Availability: Patients may occasionally experience a behavioral health crisis and will call their primary care provider. When there is a primary behavioral health concern, would physicians in the practice prefer that the behavioral clinician handle these calls?

Chapter 7

Characteristics and Competencies of Successful Behavioral Health Providers in Integrated Primary Care

The initial sections of this chapter are relevant for medical providers, healthcare administrators, and clinic managers who are involved in hiring or contracting behavioral health clinicians for integration into their primary care practices.

Behavioral health clinicians may also benefit from a review of desirable and undesirable characteristics that relate to success or failure in the integration of behavioral treatment services. The latter sections of the chapter discuss the array of competencies that have been established for behavioral providers in pediatric integrated primary care (IPC). Although written by and for psychologists, these competencies, in large part, are applicable to all behavioral health professionals, across disciplines, who work in primary care.

Prerequisite Legal and Licensing Requirements

Behavioral health clinicians involved in the integration of behavioral health into pediatric primary care must first meet legal and administrative requirements for providing behavioral health services, as discussed in previous chapters. These include an approved internship and some degree of supervised experience leading to state licensure to practice in a recognized behavioral health profession (psychiatry, psychology, social work, marriage and family therapy, psychiatric nurse practitioner, or counseling). Managers who interview or are involved in hiring, as well as behavioral health applicants themselves, should be aware of the requirements for licensure in their respective states. For behavioral health providers applying to transition licensure to a new state, familiarity with the standards of that state's requirements can expedite the licensing process and reduce the length of time before the clinician can bill independently.

Generalist Orientation and Training

Behavioral health providers with some background in medical settings are generally better prepared for integrated primary care practice than those from training programs that emphasize private practice and long-term therapies. At the present time, while there are increasing numbers of graduate programs adopting training in integrated care approaches, it is still unusual to find providers who have experience, knowledge, or training in pediatric primary care medical settings (Hall, Cohen, Davis, et al., 2015).

Similar to the practice of medicine, some clinicians are not trained in the competencies to be successful in a primary care practice. Some may choose to specialize in a particular disorder and become experts in that branch of behavioral health. Most university medical centers, for example, provide specialty services in a myriad of health disorders. Specializations abound for behavioral health clinicians wishing to work with medical services such as gastroenterology, diabetes, epilepsy, neurology, rheumatology, autism, etc. In these specialty clinics, behavioral health clinicians develop strong expertise in the treatment of a single or a small cluster of related disorders. One colleague, specializing in obsessive-compulsive disorder (OCD), has restricted his practice to only seeing patients with this condition. He has expertise in evaluating and treating OCD, is recognized nationally, and has published multiple papers, all on the diagnosis and treatment of OCD. By contrast, behavioral health professionals working in integrated care need to have a "generalist" perspective and the capacity to assess and treat the wide variety of behavioral health disorders that present in primary care. Pediatric behavioral health clinicians are expected to be able to address problems ranging from internalizing disorders (e.g., depression, anxiety, suicidal ideation), externalizing disorders (e.g., oppositional defiant disorder, mood dysregulation, conduct disorder), neurodevelopmental disorders (e.g., autism, attention deficit hyperactivity disorder), adjustment disorders (e.g., due to divorce, moves, death of a loved one) and behavioral issues that are comorbid with physical conditions (e.g., enuresis, encopresis, diabetes, epilepsy). In addition, behavioral health providers in integrated primary care are very frequently involved in preventive interventions such as parent education, teaching appropriate discipline strategies for children, toilet training, developmental assessment, negotiating the process of accessing special education services, and consulting with school personnel.

In addition to being trained to address a wide range of presenting behavioral health concerns, certain personal characteristics and learned competencies are integral to effective practice as a provider in an integrated primary care setting. The remainder of this chapter discusses the characteristics of successful and unsuccessful clinicians for practice in integrated care and those overall professional competencies required, both within the primary care clinic and the surrounding community.

Behavioral health providers with some background in medical settings are generally better prepared for integrated primary care practice than those from training programs that emphasize private practice and long-term therapies.

Barriers to Successful Integration

Several authors have written about the types of personal characteristics necessary for behavioral health professionals to successfully work in integrated primary care practices (Robinson & Reiter, 2007, 2016; O'Donahue & James, 2009). Additionally, we have had more than twenty years of experience in assessing the characteristics of trainees who have been successful, and some who have been unsuccessful, in working within pediatric primary care clinic settings. Just as there are necessary and beneficial characteristics, there are also characteristics that are undesirable for success in the integrated care setting. Some of these characteristics are personal traits, and

some have been taught in graduate programs that emphasize a more traditional approach to therapy. In the latter situation, one of the basic questions for hiring or contracting managers is whether the provider is capable and willing to learn new approaches to clinical work, including brief therapies, a population orientation, salesmanship, sharing of patient information and adherence to evidence-supported protocols.

Difficulties Establishing and Sustaining Relationships. Establishing integrated practices requires frequent communication and teamwork. It requires being comfortable with engaging with others, seeking out and providing consultation, and being accessible, flexible, and visible to promote collaboration. Individuals who are uncomfortable in or avoid social interactions with supervisors or colleagues will usually have difficulty in an integrated care clinic. Such individuals may be excellent at certain clinical tasks, such as standardized psychological assessments but find establishing relationships with other primary care treatment team members and community agencies challenging.

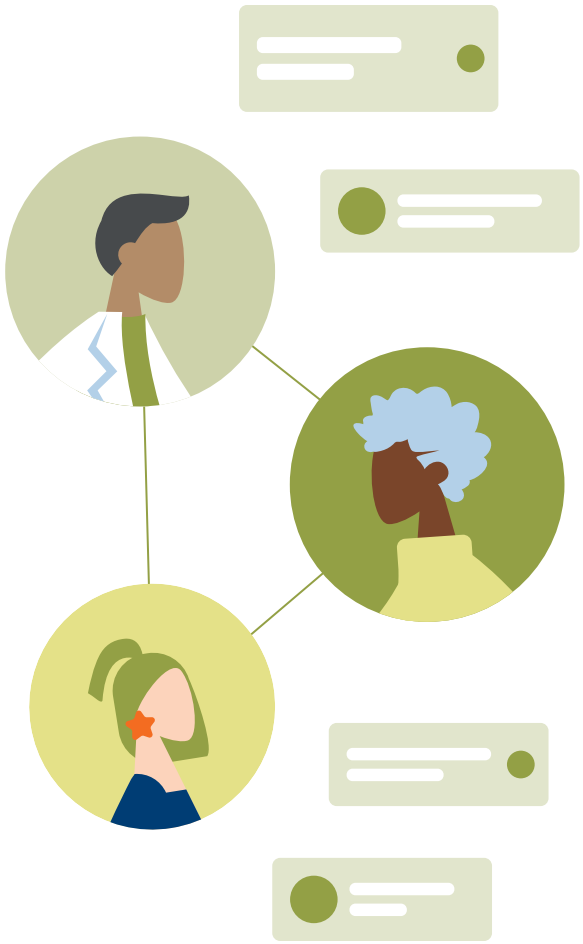
Clinicians who prefer to stay in their office (aka "office lingerers") and do not interact with receptionists, support staff, nurses, and physicians make it difficult to become integrated primary care team members. For example, one postdoctoral trainee was provided with an office in a space outside of the active clinic practice in a connected hallway. Rather than spending time with physicians and nurses in the flow of the clinic, she stayed in her office and avoided spending time with clinic staff in the break room or the front office where physicians and staff normally congregated. It required replacing this provider and several months of intentional physical presence and social integration within the clinic by a new behavioral health provider to reestablish successful staff relationships.

Long-Term Therapy Approach. One of the goals of the "Quadruple Aim" in healthcare is increasing access to services for the population in general (Bodenheimer & Sinsky, 2014). As indicated in Chapter 1, in traditional behavioral health treatment facilities, the focus of care is on coping and not upon prevention or early intervention. Consequently, treatment focuses on weeks of therapy instead of targeted, short-term treatment. One hospital program, attempting to introduce integrated care, insisted upon a model where patients were initially seen in primary care but then referred to a central behavioral health practice where they were seen an average of fourteen to fifteen times. In this scenario, assuming 1,200 hours of direct client contact each year, a total of eighty patients could be seen from a typical small clinic serving 3,500 children, adolescents, and their families. In pediatric practice, approximately 20 percent of patients (in this case, 700 children and adolescents) statistically have diagnosable behavior disorders, but the traditional approach to therapy limits access to care for the majority of patients in need. In the above example, multiple full-time behavioral health providers would be required to serve this clinic's needs. This is not feasible for most primary care clinics.

Rigidity. The culture and pace of primary care requires adaptability and a significant degree of flexibility. Behavioral health clinicians must be open to frequent interruptions, seeing patients who have not been scheduled, establishing emergency appointments for triaged patients found to be most in need, and being comfortable in sharing electronic health record information with physicians and other healthcare providers. When a clinician objects to any

of these “cultural characteristics” typical of a primary care practice, this is usually a sign of future difficulty in being part of the integrated care team.

Discomfort Addressing a Range of Presenting Needs. If a behavioral health provider in an integrated practice expresses concern about seeing patients with a wide variety of disorders, this can be another indicator of difficulty in adapting to the primary care setting. Primary care providers and behavioral health providers are traditionally trained to view health in ways that are both culturally and organizationally different. While primary care physicians are often focused on preventing disease through screening and minimizing the course of treatment through early detection and treatment, psychologists and behavioral health providers are often trained to diagnose and treat disorders. One clinician placed in a Federally Qualified Community Health Center was trained traditionally and advocated for only seeing adult patients with depression and anxiety, for which she was most comfortable and best prepared. The clinician was eventually replaced because she was referring more than 60 percent of patients to outside agencies, which was not viewed as responsive to the needs of the primary care practitioners in the clinic.



Characteristics Facilitating Successful Integration

Willingness to learn and the desire to be part of a treatment team are positive signs for eventual success in integrating behavioral health services. Other strong selection considerations include the following:

Pro-Social Skills. Successful behavioral health clinicians have highly developed skills in relating to patients, parents, healthcare colleagues, and office staff. Clinicians who initiate and engage comfortably in social interactions, frequently make positive comments, recognize and praise effort, and avoid being openly critical, are well-suited for integrated care practice. Spending time with medical providers and administrative personnel, however brief, is an expectation and helps to define the role of the behavioral clinician as well as inform staff about the behavioral health services that can be provided within the primary care clinic. In addition, the ability to relate to parents and children requires social capacity. For example, some families can be quite intimidating and resistant to treatment suggestions. Having the social skills to work around these barriers can be crucial to successful treatment. Demonstrated treatment successes are key to fostering continued and sustained integration.

Flexibility. As noted earlier, the culture of primary care is fast-paced and easily accessible (same-day appointments) and is comprised of teams that are efficient and flexible. Successful behavioral health clinicians need to be flexible in order to accommodate patient needs and clinic operations. Crying youngsters in need of vaccinations, warm handoffs, interruptions, and emergencies are common, and the behavioral health clinician must be able to adjust to these occurrences to keep pace with the workflow. One example of flexibility is accommodating late afternoon scheduling for families who are reluctant to pull their children from school for appointments. Another example is reserving emergency slots for same-day appointments to accommodate needs that arise, as is often customary in primary care.

Salesmanship. Although not unique to IPC settings, successful behavioral clinicians not only have knowledge and skills in a variety of treatment protocols but also have the capacity to "sell" recommendations to children, teens, parents, families, and primary care team members. Convincing parents to change their current styles of interacting with their children, disciplinary procedures, handling of adolescents, and overuse of punishment procedures are just a few areas in which salesmanship is required. The behavioral health clinician needs to be able to display empathy and concern but at the same time convince parents that most child misbehaviors are learned and therefore can be unlearned and replaced with more appropriate behaviors. Successfully working with resistive parents requires capability in selling behavioral technology while at the same time reinforcing and shaping parental effort.

Integrated behavioral health providers should also be skilled at relating to adolescents who, in general, do not want to be there, have often been scapegoated as the source of family conflict, are resistant to behavior change, and feel that therapists are aligned with parents against them. One of the best comments from an adolescent in the primary clinic setting to a primary care behavioral health clinician was, "You are the first therapist who didn't blame me for everything and made me feel that you were on my side."

In a similar vein, selling the primary care team on ways to modify their practices as an integrated care team is important. For instance, working with the primary care providers on how they will introduce the idea of referring a child and family for behavioral services is important. Creating a standardized behavioral health referral 'spiel' for PCPs to introduce to a child and family may be useful for all team members to consider. If everyone in the practice is convinced that behavioral health is part of overall health and not a separate and mysterious service, then families receive a consistent, calm message about behavioral health. Selling the primary care team on ways to introduce common behavioral strategies during anticipatory guidance at well visits may help the behavioral health provider and the primary care team use similar language and share similar views on effective procedures such as time-out, media use, and safety recommendations. In one practice, the behavioral health team and the primary care team worked together on anticipatory guidance for effective behavior management procedures provided during all well visits for patients between ages three and eight years of age.

Willingness and Competence to Address Presenting Concerns. Behavioral health clinicians and primary care providers can successfully address and treat most (we estimate 85 percent to 90 percent) behavioral disorders initially referred within a pediatric primary care practice. Successfully integrated behavioral health clinicians are generalists and are open to seeing all types of initial referrals within the clinic. For example, primary care providers regularly send teens who appear to be clinically depressed or who have expressed some degree of suicidal ideation on screening measures to a hospital emergency department, often at the cost of $2,500 to $5,000 for evaluation by a team of hospital-based psychiatric providers. By contrast, well-trained behavioral health clinicians can conduct risk assessments and provide brief interventions, referral to specialty care, and confirm needs for emergency services. One IPC program in Pennsylvania estimated savings of over $500,000 in unnecessary emergency department referrals by having behavioral health clinicians provide risk assessments for adolescents within eleven practices.

While integrated behavioral health providers are expected to initially see all patients with behavioral problems presenting in the primary care clinic,

Behavioral health clinicians and primary care providers can successfully address and treat most (we estimate 85 percent to 90 percent) behavioral disorders initially referred within in a pediatric primary care practice.

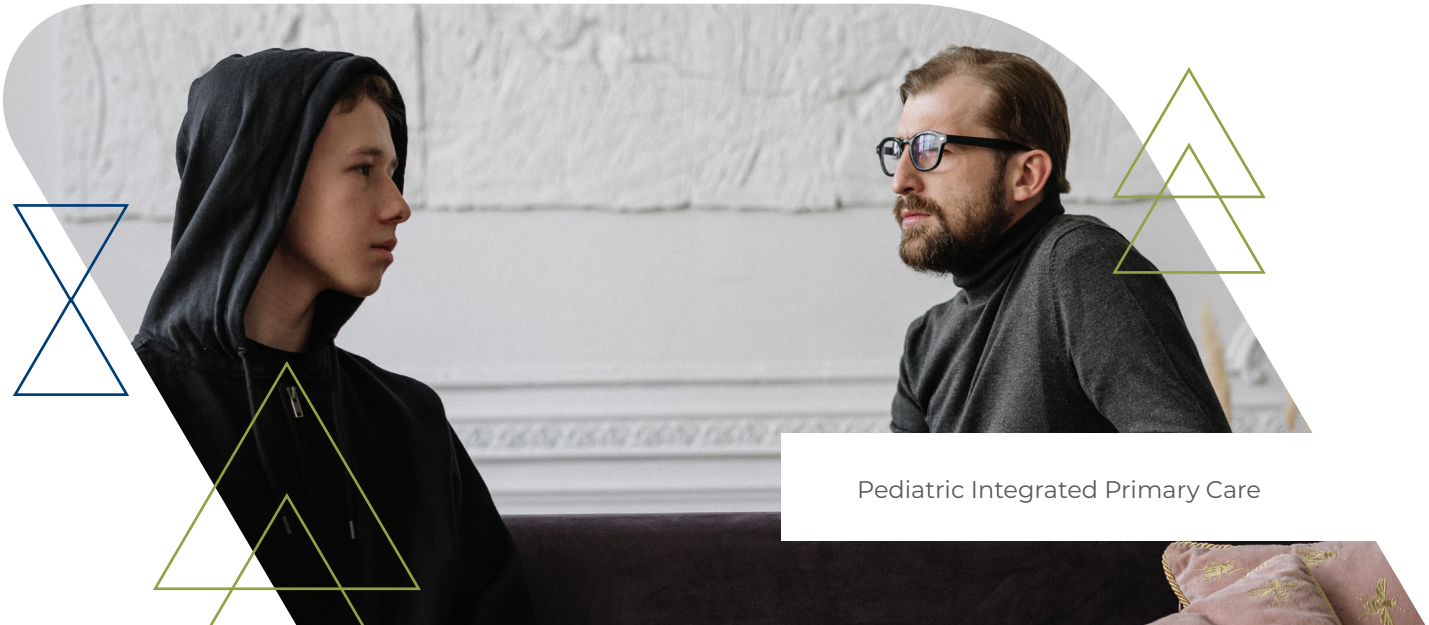
successful clinicians are trained to assess needs and make referrals for those 10 percent to 15 percent of patients requiring long-term therapy or more intensive services. Some examples of issues needing referrals due to the inappropriateness of services in integrated primary care include child custody evaluations, treatment for autism spectrum disorder, and marital therapy for parents. Primary care physicians tend to support appropriate referrals when their integrated behavioral health providers determine that the best care for their patients is a more intensive level of care.

Ability to identify and address social determinants of health. Successful behavioral health clinicians relate well to patients and families across the socioeconomic spectrum. Although some families may be concerned with improving their parenting skills, others may be more concerned with treating defiance, conduct disorder, depression, and school failure. Successful IPC teams also consider social determinants of behavioral health, including transportation, unemployment or underemployment, marital discord, school functioning, food insecurity, family history, parental mental health, and community safety. These factors can significantly interfere with treatment. Successful IPC teams work with case management or, in the absence of this service, make referrals to social service agencies and address barriers to treatment to the degree possible. For example, IPC teams may decide to provide telehealth services to families with transportation limitations or arrange appointments for late afternoon hours when sessions interfere with parent work schedules.

Collaboration. The "Quadruple Aim" for healthcare provision includes enhanced patient experience, improved population health, reduced costs, and improvements in the work life of healthcare providers. Successful behavioral health clinicians in primary care settings collaborate with physicians, nurse practitioners, and physician assistants in addressing these aims. Working as a team, physical and behavioral health providers can manage and treat most behavioral conditions presenting in primary care. Collaborations can involve joint sessions with patients and families. Primary care providers often acquire behavioral knowledge that allows them to offer preventive and first-line interventions after being exposed to behavioral health protocols from their collaborating behavioral health clinicians. For example, one physician became familiar with discipline strategies for younger children and began to routinely provide anticipatory guidance on appropriate discipline for families with this acquired knowledge. For families with greater difficulties, the behavioral health clinician is available for hallway consultations or as a referral source for the patient and family.

Competencies for Behavioral Health Clinicians in Integrated Pediatric Primary Care

In 2012, the president of the American Psychological Association issued a call for a compilation of competencies required for primary care psychology in six domains: science, systems, professionalism, relationships, applications, and education. The result was a 2014 article in the *American Psychologist* journal delineating definitions, essential components, and sample behavioral anchors. Since this document was prepared by professionals primarily working in adult settings, a similar compilation of competencies



for psychologists working in pediatric medical settings was published in the *Journal of Pediatric Psychology.* This document mirrored the earlier work but with a focus on psychologists working in medical settings, particularly hospital specialty care, for children and adolescents.

Although initially designed for the field of psychology, there are components of each competency area that are applicable to all behavioral health professionals.

Focusing specifically upon the subset of psychologists working in primary care medical settings, the Society for Pediatric Psychology published a set of competencies specific to working in pediatric primary care. This document, published in the *Journal of Pediatric Psychology*, lists and defines competencies and behavioral anchors specific to providing pediatric integrated behavioral health in primary care medical practices. The remainder of this section will briefly discuss these competencies. Although initially designed for the field of psychology, there are components of each competency area that are applicable to all behavioral health professionals, including social workers, marriage and family therapists, psychiatric nurse practitioners, and counselors working in pediatric and family medicine practices.

Professionalism:

- Exhibits professionalism in interactions with patients and families
- Provides clinical care to children and families implementing appropriate personal boundaries
- Works effectively with colleagues from other disciplines
- Utilizes educational opportunities regarding the profession and relevant areas of medicine
- Works effectively with patients and families of diverse backgrounds
- Applies professional standards associated with the practice
- Follows local laws and guidelines regarding the rights of children and caregivers
- Engages in self-awareness, including one's own health behaviors and reactions to stress
- Conducts self-assessments to continually improve services offered
- Uses and facilitates accurate, clear, and effective communication with patients, families, other professionals, institutions, and systems
- Supports a team approach to the maintenance and promotion of health
- Develops and maintains relationships with patients, families, other professionals, communities, and systems
- Effectively manages challenging relationships and interactions

Application:

- Meets the needs of patients, families, other team members, and the setting
- Applies principles of population-based care from prevention and wellness to subclinical problems and acute and chronic clinical needs
- Operates at a variety of paces consistent with primary care
- Can co-interview, co-assess, and co-intervene with other primary care providers
- Understands how payment for services may influence the type of services and treatments provided
- Communicates information addressing patients' needs
- Uses up-to-date technology and methods to guide service delivery
- Flexibly uses multiple methods of assessment
- Effectively assesses biopsychosocial, developmental, environmental, and family systems factors
- Selects, administers, scores, and interprets assessment tools appropriate to patient development level

- Effectively communicates the results of assessments in written and verbal form to patients and other health professionals
- Demonstrates treatment-planning skills and case conceptualization
- Implements evidence-based biopsychosocial treatment interventions
- Implements evidence-based wellness, health promotion, and prevention interventions
- Effectively communicates progress in written and verbal form for patients and other health professionals
- Integrates best available research
- Provides consultative services to healthcare professionals across disciplines and systems
- Translates and communicates relevant clinical findings

Education:

- Applies teaching strategies demonstrating knowledge, skills, and competencies for service provision in primary care
- Provides education and training to healthcare professionals and trainees
- Models and encourages commitment to integrated care through professional conduct and integration of ethical principles
- Outlines competency expectations for practicum, intern, postdoctoral, and resident trainees and provides feedback
- Provides effective behavioral health supervision to trainees from all health professions

Systems:

- Understands basic principles of systems theory
- Understands the roles, responsibilities, and interrelationships of multiple disciplines
- Understands the basic knowledge, perspectives, service delivery systems, and contributions of other healthcare disciplines
- Understands health systems collaboration, enhanced outcomes, and how to evaluate outcomes
- Has knowledge of system-based assessment approaches across treatment settings including outpatient, inpatient, schools, and community
- Has knowledge of and can apply continuous performance improvement models
- Engages in the role of behavioral health provider as a knowledgeable team member understanding behavioral aspects of medical disorders
- Is familiar with roles of management, administration, and other peer team members
- Advocates for behavioral health as an evidence-based science
- Advocates for access to behavioral health at all levels of the healthcare system: individual, family, institutional, and political

Science:

- Conducts research across multiple settings
- Effectively uses research skills to evaluate practice, interventions, and program outcomes
- Acquires familiarity with clinical trials methodology and research strategies
- Acquires familiarity with intramural and extramural funding
- Understands and applies regulations for protection of patients as subjects
- Understands and appropriately handles ethical issues related to interdisciplinary research
- Functions within interdisciplinary research teams
- Develops and uses strategies to translate research findings to multiple audiences

Tips and Take-Home Points

- Not all behavioral health clinicians are well-suited for integration into primary care medical practices.
- There are certain competencies, derived from integrated psychological practice, that are applicable to most integrated behavioral health professions.
- Characteristics that are undesirable for integrated primary care practice include: shyness, rigidity, insistence on long-term therapy, unwillingness to see a wide variety of patients, and lack of positive social skills with patients and staff.
- Desirable characteristics for integrated care behavioral professionals include: flexibility, positive social skills, willingness to see patients with all behavioral health conditions, salesmanship skills, ability and willingness to collaborate, and ability to relate to all socioeconomic classes of families.
- Competencies for integrated behavioral health providers include proficiencies in professionalism (appropriate interactions with patients and staff and self-assessment), application (use of appropriate assessment and treatment skills), education (for community members and staff), systems (understanding and use of a variety of systems impacting behavioral health), and science (knowledge and use of evidence-supported care).

Chapter 8

Developing Relationships in Integrated Primary Care

This chapter is written for behavioral health clinicians new to integrated primary care (IPC).

Although this may seem obvious, one of the more important components of successful pediatric integrated primary care practice is relationship development within the primary care practice and community. While some clinics are extremely welcoming, others may require some concentrated effort to make the behavioral health provider part of the clinical practice team. In this chapter, we present some of the barriers typically encountered in program implementation and discuss some successful strategies for establishing, maintaining, and sustaining integrated primary care.

A recent study revealed that patients prefer to have behavioral health needs addressed in the primary care clinic rather than being referred to a community-based behavioral health provider. Therefore, in order to successfully address the behavioral health needs of patients, positive relationships between primary and behavioral health team members are critical. If behavioral health services are viewed as beneficial to patients, healthcare providers (physicians, nurse practitioners, physician assistants), and office staff members, then probabilities for success and a positive working environment are greatly enhanced. Conversely, behavioral health providers who are viewed as placing extra burden upon staff or are demanding, inflexible, or difficult decrease the probability of successful integration and ultimately do not meet the behavioral health needs of patients. We provide suggestions on ways to positively interact with staff and healthcare providers so that the behavioral health clinician is fully accepted and becomes a participating member of the overall primary healthcare practice.

In order to successfully address the behavioral health needs of patients, positive relationships between primary and behavioral health team members are critical.

Relational Barriers

When introducing integrated primary care practice, one should be aware of the patient flow through the clinic and job requirements of support staff in clinic operations. For example, how busy are front office and reception staff in providing support services? If busy staff members (insurance verifiers, schedulers, billing clerks, etc.) view the behavioral health provider as adding more work to their already busy schedule, relationship development with the support staff can be difficult. By way of example, in one of the clinics we worked to establish, this presumably “extra burden” created some passive resistance to integration

from staff until relationships had been developed. Luckily, behavioral health providers do not require substantial resources and, whenever possible, we strongly suggest initially negotiating time with support staff; this might include reception, gathering insurance information, scheduling, and notifying behavioral health providers when patients check-in for appointments. It is best if these arrangements can be in place when the behavioral health provider is introduced into the clinic setting. It is often helpful for the integrated care team to meet to discuss short- and long-term goals and needs to improve practice. There are often more opportune times to make changes that do not require immediacy. For instance, if the practice website is scheduled to be updated, one can take this as an opportunity to make updates to forms and other behavioral health material on the website during that upgrade.

A second potential barrier for behavioral health providers in developing relationships with primary care medical providers relates to training in their profession. Primary care physicians are taught to be generalists, able to respond to all types of healthcare problems, including those with behavioral health conditions. Some physicians are quite good at addressing behavioral health issues and often do not see a need for additional providers. Even within a single practice, there may be differences in the opinions of physicians as to the need for behavioral health services. In one pediatric practice, for example, very few referrals were forthcoming from one of the older, more experienced physicians until a crisis situation occurred and the behavioral health clinician was able to demonstrate skills in handling this specific incident. Later, as positive relationships developed, this physician became a major referral source for the behavioral health clinician.

Another potential barrier for relationship development is the prior experience of physicians with behavioral health services. On one hand, physicians may have a reliable provider in the community with whom they have confidence in making referrals. In situations like these, it was helpful for the integrated primary care team and the community behavioral health teams to meet and discuss appropriate referral practice based on diagnosis, treatment required, and areas of expertise. We were significantly delayed in integrating behavioral health into a family medicine clinic because the physicians were concerned about upsetting a trusted community provider. Establishing relationships often involves partnering with community agencies and providers to develop a collaborative, well-defined approach for referrals.

Practice Relationships

In this section we will discuss tips for behavioral health providers in developing positive relationships within the clinical practice site.

- Develop relationships with *all* primary care staff, including physicians, nurses, physicians' assistants, nurse practitioners, and office/support staff.
- Establish a positive relationship with the clinic's behavioral health champion who is most often the leader within the practice and who has the respect of other providers and staff in the clinic. Sometimes this champion is a nurse manager, pediatrician, or office manager. If a champion is not initially identified, behavioral health providers should identify which clinic member might assume that role. Effort should be made to ensure positive relationships with all primary care providers and hopefully develop more than one champion over time.
- Share treatment notes with the primary care team as soon as possible. Prior to completing notes and sending them to the primary care team's EHR, provide brief verbal and/or written feedback to referring primary care providers as soon as possible. Brief feedback (one paragraph describing a plan and any important updates and a thank you for the referral) reinforces primary care practitioners referring their patients with behavioral concerns.
- Report patient progress in treatment following services, verbally or through brief notes. Reporting treatment successes adds to credibility.
- Invite and allow interruptions during sessions. In order to fit into the culture of primary care, be prepared to allow nurses, PAs, and physicians to interrupt sessions for warm handoffs, brief consults, and problem solving. Considering the busy schedule of a primary care physician (twenty to thirty-five appointments per day), PCPs may need assistance in determining the appropriateness of referring to integrated behavioral health services within the clinic or making referrals to outside sources for more involved behavioral treatment. Agree to be pulled into sessions being conducted by physicians or other medical healthcare providers.
- Expect an internal referral from within the practice. In the absence of other community behavioral health resources for referrals (such as in rural areas), a redefining of the parameters of the dual relationship between the behavioral health clinician and an employee or colleague needs to be considered. Whether you plan to accept these referrals is an important discussion point with the primary care team prior to starting practice in the clinic. If accepting patients from within the practice, it should be noted that internal referrals require special attention as they establish credibility (or the lack thereof) of the behavioral health clinician with members of the clinic. In the case that there is a team decision against accepting internal referrals from clinic providers, staff, and families, referral options should be made available with other colleagues or trusted providers.
- Use evidence-supported diagnostic and treatment protocols with handouts (written or digital) containing descriptions of treatment procedures to be used in the home or school.
- Provide consultation about behavioral healthcare to physicians who request support in implementing treatment protocols with their patients.

In order to fit into the culture of primary care, be prepared to allow nurses, PAs, and physicians to interrupt sessions for warm handoffs, brief consults, and problem solving.

- Volunteer to handle difficult behavioral problem phone calls from patients. Nurses and support staff frequently handle emergency calls and complaints. For those calls involving behavioral issues, the behavioral health provider is usually better equipped to deal with such issues.
- Be available to assist in handling difficult patients, such as young children requiring vaccinations, by employing and demonstrating behavior management strategies (such as the use of reward-based protocols or brief exposure for needle anxiety).
- Assist healthcare providers giving unwelcome news to families whose child has a serious disorder or

prognosis. Provide emotional support to both family and healthcare providers.

- Be prepared to conduct self-harm risk assessments. Use established protocols for screening and determination of need to refer to hospital emergency departments.
- Participate in clinic staff meetings and volunteer for projects, such as quality improvement projects for the primary care practice.
- Express gratitude to staff for support services provided, such as gathering adequate insurance information, scheduling patients, calling patients, etc. On occasion, bring treats for clinic staff such as brownies, cookies, donuts, etc. Send cards or emails to staff for birthdays, Christmas, anniversaries, etc.
- Look for opportunities to make positive statements and praise for all types of accomplishments of physicians, PAs, nurse practitioners, nurses, support staff, or groups of staff.

Look for opportunities to make positive statements and praise for all types of accomplishments of physicians, PAs, nurse practitioners, nurses, support staff, or groups of staff.

- Offer to provide brief presentations over lunch hours covering topics that may be of interest to the clinic staff (such as appropriate discipline for young children, toilet training, school readiness, etc.).
- Participate in the social activities of the clinic and with individual providers. For example, participate in office holiday parties and accept invitations from staff for dinners, gatherings, weddings, etc.

Community Relationships

The findings of a recent meta-analysis revealed that the majority of youth in the general population receive mental and behavioral healthcare in the schools and outpatient behavioral health settings. Therefore, emphasizing relationships with community agencies, schools, hospitals, and private providers is important for the integrated primary care team for several reasons. First, there will be occasions when more intensive services or specialty care will be needed. Although this may only be 10 percent to 15 percent of patients seen, the integrated behavioral health clinician needs to be familiar with programs or specialty mental healthcare services available within the community or surrounding area. For example, referrals for drug and alcohol treatment, court-ordered custody evaluations, eating disorders, or child abuse and neglect assessments are all outside the parameters of short-term, brief interventions within the Primary Care Behavioral Health (PCBH) model. Therefore, developing relationships with community agencies and private providers can enhance the referral process to these programs, as well as ensuring that patients get access to the most appropriate treatment services available.

Second, the treatment process with children and adolescents often involves significant interaction and collaboration with community programs. For example, treatment of ADHD often requires teacher ratings, data collection on child behavior in the classroom, and establishment of behavioral interventions between school and home. Similarly, some families may be without the financial means to obtain healthcare. Knowledge of, and relationships with, local health department or social service agency personnel can expedite the referral process for families to enroll in CHIP (Children's Health Insurance Program) or eligibility for Medicaid.

Third, while the majority of referrals for integrated care come from within the primary care practice, community organizations and schools will often encourage families to seek behavioral help from their primary care practitioners when it becomes known that behavioral health services are available. For example, agencies serving families of children with developmental disabilities may not have the internal staff capable of providing behavior management strategies for parents. Consequently, they may encourage families to seek services through their child's primary care medical practice, knowing

that behavioral health is part of the array of clinical services offered. As noted earlier, the decision to serve families from outside the primary care practice should be made with careful consideration. (See further discussion of this issue in Chapter 6.)

The overall size of the primary care clinic, numbers of patients served, geographic distribution of patients and families, and availability of other behavioral health agencies within the community are all factors that will influence the development of relationships between the integrated behavioral health professional and community providers. Development of relationships with community behavioral health agencies and programs requires effort over time but is ultimately of value for successful integrated care. Toward this end, we have developed some recommendations for establishing relationships with community providers and support agencies.

- Determine which schools serve the majority of the primary care clinic's patient population. For those schools with the largest number of patients served, meet with the principals, special education directors, and school psychologists. Establishing these relationships may be key in obtaining needed information from the school, requesting progress monitoring, and getting teachers to apply behavioral recommendations.
- Offer to make presentations to the local Parent Teacher Associations (PTAs). PTAs often seek speakers for their meetings, and this also provides an opportunity to discuss behavioral services available in the primary care practice.
- Establish contacts with billing representatives from major insurers of patients within the practice. This can assist the practice's billing staff when coding or coverage questions arise. Appealing denials can be facilitated through relationships with specific reviewers who can be educated about the behavioral healthcare provided through the primary care practice.
- Locate and meet with emergency department representatives in hospitals with the capacity to conduct suicidal evaluations and psychiatric care.

This can facilitate referrals for those patients assessed as being of considerable risk for self harm.

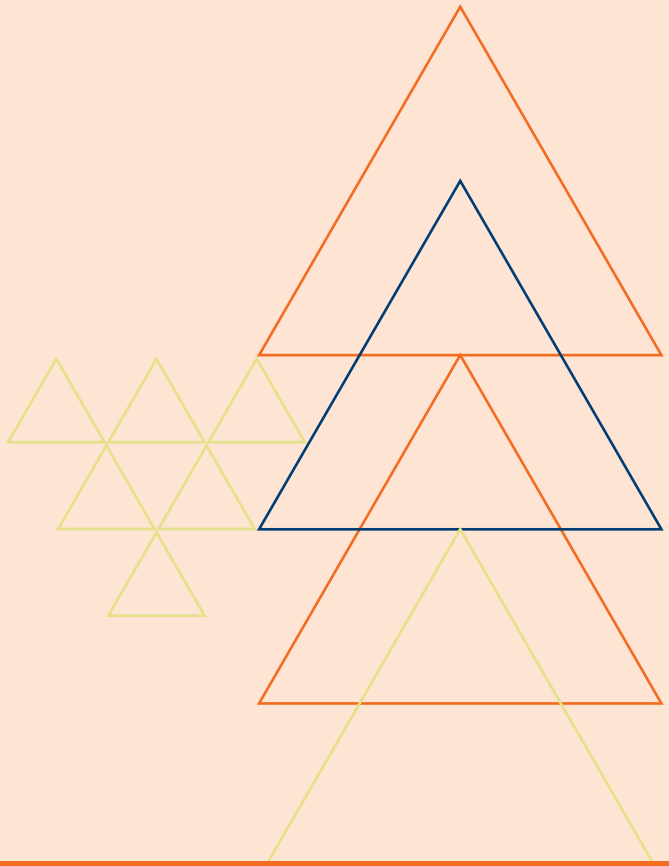
- Determine what specialty mental health services are available within the surrounding community or in nearby cities or towns and meet with directors or admissions coordinators to determine referral processes and information needed for referrals. Collect brochures of services from these agencies.
- Develop brochures describing behavioral health services available to schools, community agencies, hospitals, and private specialty providers. A sample brochure is included in the supplement to this manual.

Conclusion

Relationships within the primary care practice, as well as with community agencies, are key when working within integrated primary care. Patients prefer having their behavioral health concerns managed in the primary care setting (Dunn, Garneau & Filipowicz, 2021), and therefore emphasizing relationships and teamwork enhances the behavioral healthcare delivered by the entire integrated care team. Additionally, although most behavioral health concerns can be managed by the integrated primary care team, access to community providers and agencies (e.g., schools, hospitals, and specialty outpatient programs), is important for providing the best behavioral health care possible. Positive relationships within the primary care practice and between primary care and community agencies will greatly increase the quality and continuity of overall healthcare for patients.

Tips and Take-Home Points

- For the primary care practice to view integrated behavioral health as adding value, positive relationships need to be developed within the clinic and the community.
- Barriers to developing relationships include staff viewing behavioral health as a burden to their already busy schedules, poor past relationships with behavioral services from other agencies, and some physicians/providers who feel obligated to provide behavioral care themselves and may be resistant to providers within the clinic.
- Relationships should be established with *all* staff members in the clinic, particularly with the physician/provider champions who are supportive of behavioral health.
- Relationships are often governed by the credibility of the behavioral health provider. Credibility can be established through frequent communication with referring physicians about their patients, reports of successful treatments, willingness to take warm handoffs, volunteering to handle difficult patients, and presentations to clinical and support staff.
- Not all patients are appropriate for short-term, targeted interventions. Community relationships need to be developed for making referrals to agencies and programs offering specialty care, including mental health centers, hospital emergency departments, community treatment programs, schools, and special education programs.



Chapter 9

Screening for Behavioral Health Concerns in Primary Care

Up to 50 percent of patients with depression are overlooked within the primary care medical setting (Mitchell et al., 2009).

Studies have further found that 20 percent to 70 percent of patients served in primary care clinics have treatable mental health conditions (Cummings, 1997). In pediatric primary care, estimates are that, at any one time, 20 percent of children and adolescents have diagnosable behavior disorders (Levigne et al., 2008). At the same time, less than half of children with a mental health disorder received needed mental behavioral health treatment. In the field of child and adolescent behavioral health, patients most often seek services initially from their trusted pediatric primary care providers (Wildman et al., 2004; Wissow, Ginneken, Chandna, et al., 2016).

With limited access and availability of behavioral health resources, primary care practitioners (PCPs) have become the de facto behavioral health providers for the majority of individuals with mental/behavioral health difficulties. For example, data suggests that, in the absense of available behavioral health resources, there has been a major increase in the use of psychotropic medications for children and adolescents by medical practitioners over the past decade.

Despite being seen as a source of behavioral treatment by their patients, the majority of pediatric PCPs report being inadequately prepared for this role (Shahidullah et al., 2018). By way of example, behavioral health training during a three-year residency for primary care physicians generally involves a one-month rotation in psychiatry or health psychology. Given the lack of available behavioral health referral sources, particularly in rural practices, many medical providers have little choice other than to provide treatment, typically with psychotropic medications, for their patients. By contrast, with

the advent of the Primary Care Behavioral Health integration model, PCPs can now have access to behavioral health assessment and treatment services provided by licensed professionals with three to six years of education and experience specifically in the assessment and treatment of mental health disorders. Behavioral health providers are trained and licensed to identify and treat early onset and acute behavioral health concerns while referring chronic cases to specialty care. The remainder of this chapter addresses the identification of patients with potential behavior disorders through the adoption of behavioral health screening measures.

Why Screen for Behavioral Health Concerns?

Despite increasing acceptance of behavioral health concerns as part of normal life experience, there currently remains a "stigma" about seeking behavioral health services for one's children, adolescents, or self. This is often the reason that parents initially seek out a PCP to determine whether there is an underlying physical disorder causing behavioral symptoms of concern. Many parents are informed that their child's behavioral problems are just a "stage" in development that will eventually go away. Still other parents recognize "something wrong" in the behavior of their child but do not know what to do and, consequently, turn to their medical provider for assistance. Finally, some parents simply want to improve their own parenting skills but are reluctant to see a behavioral health professional and instead seek out advice from their child's medical doctor. Unfortunately, within pediatric primary care, the behavioral needs of children, adolescents, and families are often missed. Screening can help by:

- identifying children and adolescents with potential behavior disorders
- identifying and offering preventive measures
- identifying children and adolescents in need of further assessment or psychological evaluation
- identifying youth with potential severe mental disorders in need of more intensive behavioral health services

- identifying social determinants of health that may impact children's behavioral health
- providing information to insurers or Medicaid justifying payment for behavioral healthcare

Screening Recommendations from Professional Organizations

Several child health and pediatric organizations have made recommendations for screening children and adolescents in primary care practices. Some measures are protected and only available for purchase by licensed psychologists with specialized training in mental health measurement and evaluation. Many measures have significant costs for test kits, scoring software, and individual assessment forms.

Other measures, however, are freely available with no associated fees. Considering the various types of behavioral health professionals working in primary care and the expenses of purchasing screening assessment materials, we focus upon instruments that have no associated costs and are psychometrically sound. The behavioral health screening measures presented have been standardized for reliability, validity, sensitivity, and specificity.

It is important to note that screening measures are designed to assess potential behavioral health conditions and should not be used as diagnostic tools. Positive behavioral health screening results in an integrated primary care practice should lead to further assessment by a PCP and referral to a behavioral health provider. Screening and diagnosis are separate processes. The American Academy of Pediatrics recommends behavioral health screening as part of routine primary medical care. This chapter focuses upon screening measures that can be readily adopted into pediatric and family medicine primary care practices.

Screening measures are designed to assess potential behavioral health conditions and should not be used as diagnostic tools. Screening and diagnosis are separate processes.

Before proceeding with suggestions and samples of behavioral health screening instruments, it is important to discuss the totality of healthcare screening functions required of primary care medical providers working with children and adolescents. According to the Bright Futures document published by the American Academy of Pediatrics, screening in primary care practice should include assessment of developmental milestones, maternal depression, social determinants of health (such as food, housing, heat, etc.), family strengths, mental health (now also including autism), adolescent depression, substance abuse (including use of tobacco, drugs, and alcohol), oral health, vision, hearing, and school functioning (Hagan, Shaw & Duncan, 2017). Although an assessment for each of these physical and related healthcare conditions does not occur in every pediatric visit, the overall list of recommended measures is daunting, and schedules are needed to meet screening requirements throughout childhood and adolescence. It is, therefore, important to establish reasonable schedules and maximize time efficiency for administration, scoring, and review of screening results for patients and families within the primary care clinic.

As noted, there is a tremendous amount of screening responsibility placed upon primary care practitioners. Primary care clinics vary greatly on the types and schedules of developmental and behavioral screening practices. In some instances, larger organizations make decisions for primary care providers and implement universal screening practices. In other situations, primary care providers, even within the same clinic, may use different screening processes than their partners. Additionally, PCPs who are interested in employing developmental and behavioral health screening measures are frequently unable to implement these processes because of the lack of support staff, resources, or lack of referral sources following positive screen results.

When medical screening results indicate serious physical health problems, primary care medical providers typically make referrals to specialists, such as ophthalmologists, audiologists, cardiologists, neurologists, etc., or to agencies that provide specialty care, such as substance abuse clinics, rehabilitation facilities, trauma centers, etc. In instances when mental/behavioral concerns arise, however, PCPs report having significant difficulties in referring and getting initial appointments with child psychiatrists, psychologists, or community mental health centers. This further magnifies the need for behavioral health professionals to be integrated into primary care so major behavioral health disorders can be identified early, evaluated, and treated, thus potentially preventing the development of more severe behavioral health disorders later in life.

Approaches to Behavioral Health Screening

There are a number of ways to screen children for behavioral health conditions. Again, it is extremely important to remember that screening measures are designed to identify patients with potential behavioral health disorders. Screening measures should not be used for diagnostic purposes but rather to identify children and adolescents who may need further assessment, treatment, and/or referral. Screening tools can take the form of global measures that briefly assess a wide variety of childhood behavior disorders (e.g., scales that screen for multiple disorders such as ADHD, oppositional disorder, depression, anxiety, conduct disorder, learning problems, etc.). Other targeted measures assess specific behavioral health disorders and provide more in-depth assessment (e.g., individual measures for screening symptoms related to enuresis, drug abuse, sleep disorders, obsessive-compulsive disorder, etc.).

Behavioral Health Screening Procedures

Typically, PCPs screen for mental health and substance abuse disorders by talking informally to or interviewing patients and caregivers rather than using validated checklists or questionnaires (Ozer et al., 2005. Although professional practice guidelines and payer requirements encourage the use of standardized tools in primary care, many practitioners have not yet adopted such measures. One survey found that about three-quarters of PCPs treating adolescents regarded questioning teens about mental health problems and the use of alcohol and other drugs as their responsibility; however, only about half of these medical providers screened for mental health problems, and of those who did, only about 40 percent used a standardized tool. An interview approach alone has some significant weaknesses and frequently fails to detect behavioral and emotional problems (Glazebrook et al., 2003). One study documented that interviews conducted by PCPs accurately identified only two out of ten clinically depressed adolescents.

Initial Intake Screening. Whenever a new patient is enrolled in a primary care practice, there is commonly a history of healthcare concerns and conditions that is completed by the patient or, in pediatrics, by a parent or care provider. Behavioral health screening measures can be incorporated into this process to assist in determining any history of behavior problems and former treatments for behavioral health disorders.

Well Child Visit Behavioral Health Screening. One advantage of working with pediatric practices is that American Academy of Pediatrics (AAP) has developed guidelines for annualized well child visits in its Bright Futures manual that describes various screenings, a 'periodicity schedule' of children. Many annual well child visits occur in the summer prior to the beginning of the school year. This provides an opportunity for gathering information regarding behavioral health concerns through the use of a behavioral health screening measure at least once during the year. The periodicity schedule from the American Academy of Pediatrics also provides recommendations for the type of behavioral health screening recommended at each well child visit.

PCP Interview Screening. Since primary care practitioners assume screening responsibilities for all types of healthcare conditions, behavioral screening has typically consisted of a few questions during patient sessions for well child visits, acute healthcare visits, or chronic care sessions. Considering all the healthcare screening responsibilities in primary care, however, screening is usually abbreviated and does not employ standardized measures in an interview session. PCPs should, however, make use of standardized screening measures when concerns from parents or the youngster might arise during the healthcare examination. The behavioral health clinician can be of assistance in recommending specific screening measures, scoring screening measures, and meeting with the patient and family using a standardized interview screening format.

Universal Behavioral Health Screening. Another alternative for gathering behavioral health information on children and adolescents is the use of general screening measures for all patients, regardless of type of clinic session (acute care, chronic care, well child visits, or follow-up). This potentially ensures a higher probability of identification of behavioral health concerns and provides evidence of behavioral health screening for the electronic health record. To test this practice, we initiated a universal screening pilot study within our integrated care practices using parent ratings. Universal screening results indicated that 21 percent of 5,089 children and adolescents seen in ten pediatric and family medicine practices were screened as having possible behavioral health disorders, and 16 percent of parents reported that they could

One advantage of working with pediatric practices is that Bright Futures/American Academy of Pediatrics (AAP) developed guidelines for annualized well child visits in its Bright Futures manual that describes various screenings, a "periodicity schedule" of children (Hagan, Shaw & Duncan, 2017)

"use some help" in dealing with their child's behavior. (Note for consideration in universal screening: Some parents expressed concerns about too frequent screenings when multiple treatment sessions were required. Consequently, it is recommended that behavioral health screenings be conducted at six months intervals, or as needed, rather than for each patient visit.)

Parent/Patient-Expressed Behavioral Concern. In those cases where a parent, adolescent, or family schedules a primary care appointment to specifically discuss a behavioral concern, PCPs can select a targeted screening measure (rather than a global screening tool) specific to the expressed concern or can refer to the integrated behavioral health professional for additional evaluation and confirmation of diagnosis. In these cases, parents/patients are already aware of behavioral concerns, and the purpose of a patient/family interview is to identify symptoms related to specific behavioral diagnoses. For example, use of a measure of obsessive-compulsive disorder would be appropriate when symptoms of persistent thoughts, repetitive behaviors (e.g., repeated checking of door locks or hand washing) are present and are the specific reason for an appointment scheduled by parents. (Note: A number of specific targeted diagnostic measures and treatment protocols are discussed in online training modules accompanying this manual.)

One advantage of working with pediatric practices is that American Academy of Pediatrics (AAP) developed guidelines for annualized well child visits.

Behavioral Health Screening Tools

In the following section are two general behavioral health screening tools that have data supporting validity, reliability, and specificity and are freely available: the Pediatric Symptom Checklist (PSC–Parent and Youth self-report forms), the Vanderbilt Scales, and the Strengths and Difficulties Questionnaire (SDQ–Parent and Teacher formats with toddler and child-adolescent scoring guidelines). Both scales have applicability for use in primary care pediatric and family medicine practices. Additionally, although not considered a global measure, the PHQ-9, a screening tool for depression and risk assessment for self-harm, is presented as relevant to screening of adolescents. For further information, see Guidelines for *Adolescent Depression in Primary Care Guidelines*.

Pediatric Symptom Checklist. The Pediatric Symptom Checklist (PSC; Jellinek, Murphy & Burns, 1986) is a psychosocial screening measure designed to facilitate the recognition of cognitive, emotional, and behavioral problems of children and adolescents. There are two screening forms, one completed by parents (PSC) and a youth self-report form (Y-PSC) for adolescents aged eleven and up. The PSC consists of thirty-five items that are rated as "never," "sometimes," or "often" present and scored 0, 1, and 2, respectively. (There is also a seventeen-item version available, but this manual focuses upon use with the longer format.) A total global score is calculated for children and adolescents ages six through sixteen. Designated cutoff scores by age group indicate potential psychological impairment. A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health or licensed mental health professional.

The PSC items cover a wide range of behavioral health concerns. Included are items related to somatic complaints, inattention, hyperactivity, academic concerns, depressed mood, anxiety, and oppositional behavior. Although there is an overall score for impairment, individual items, or patterns of similar items, those rated as occurring "often" may suggest a need for further inquiry and follow-up through a diagnostic interview.

Strengths and Difficulties Questionnaire. The Strengths and Difficulties Questionnaire is a brief behavioral screening questionnaire for three to sixteen-year-olds. The SDQ exists in several versions to meet the needs of researchers, clinicians, and educators. Extended versions include items related

to impact and follow-up. All versions of the SDQ ask about twenty-five attributes, some positive and others negative. These twenty-five items are divided between five scales, each consisting of five items: 1) emotional symptoms, 2) conduct problems, 3) hyperactivity/inattention, 4) peer relationship problems, and 5) prosocial behavior. Ratings from scales one through four generate a total difficulties score. The twenty-five items are included in questionnaires for completion by the parents or teachers of four- to sixteen-year-olds. A slightly modified informant-rated version for the parents or nursery teachers of three- to four-year-olds is also available. Another version of the SDQ is available for self-completion by adolescents and asks about the same twenty-five traits, though the wording is slightly different. This self-report version is suitable for young people aged eleven to sixteen, depending on their level of understanding and literacy.

Several versions of the SDQ are available with the twenty-five items on strengths and difficulties listed on the front page and an impact supplement on the back. These versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, inquires further about chronicity, distress, social impairment, and burden to others.

Follow-up versions of the SDQ are available and include not only the twenty-five basic items and the impact question, but also two additional follow-up progress monitoring questions for use after an intervention:

1. Has the intervention reduced problems?
2. Has the intervention helped in other ways (e.g., making the problems more bearable)?

To increase the chance of detecting change, the follow-up versions of the SDQ ask about "the last month," as opposed to "the last six months or this school year."

Although copyrighted, free access to multiple versions of the SDQ is available at www.sdqinfo.org. The authors request that users go to this site and download forms to ensure that the correct version of the SDQ scale is selected, as there are multiple forms by age, type of informant, and whether additionally assessing impact and/or follow-up. The SDQ is also available in a multitude of languages for use with non-English-speaking patient populations.

PHQ-9 Modified for Teens (PHQ-9-A): Screening for Depression and Self-Harm. Although not a global screening tool, we have included the PHQ-9-A (Kroenke, Spitzer & Williams, 2001) as a measure that has utility for screening adolescents within a primary care practice. The PHQ-9-A is the nine-item depression screening scale derived from the full Patient Health Questionnaire and modified for adolescents to better represent depression in teens. Positive screens for major depression result from five or more of the nine symptom criteria being present at least "more than half the days" in the past two weeks, and with one symptom of depressed mood or anhedonia. Endorsement of the last item of the nine ("thoughts that you would be better off dead or of hurting yourself in some way") results in assessment of self-harm risk, as rates of suicide among adolescents have been notably increasing over the past two decades (Centers for Disease Control and Prevention, 2023).

Use of the PHQ-9-A screening tool can help affirm the need for further diagnostic assessment by the behavioral health provider within the primary care practice. Treatment of mild to moderate concerns can be provided within a primary care practice with referral for patients with major depressive symptoms to more intensive levels of care. The PHQ-9-A can be found within the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit (Zuckerbrot et al., 2018). Current GLAD-PC guidelines were published in

2018 in Pediatrics with an updated toolkit released in 2021. The GLAD-PC Toolkit was developed to be a real-world guide for assisting primary care providers on whether and how to implement care for depression. The PHQ-9-A and the above-mentioned screening tools may be accessed through the Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools published on June 21, 2022: https://publications.aap.org/toolkits/resources/15625/.

There is often an overlap of behavioral symptoms between child-adolescent behavioral diagnoses.

Pediatric Behavioral Health Measures for Differential Diagnosis

There is often an overlap of behavioral symptoms between child-adolescent behavioral diagnoses. For example, symptoms of difficulty in following instructions are common across children diagnosed with ADHD and Oppositional Disorder. A number of tools can be useful to assist in the diagnosis child-adolescent behavioral disorders. Many of these scales have an associated cost per copy or per usage. Some have automated scoring services available. A few of these more commonly used measures are noted below.

Eyberg Child Behavior Inventory (ECBI). This parent-rating scale consist of thirty-six items and is used to assess both the number and frequency of child disruptive behaviors (Problem Scale) and the extent to which the parent finds the child's behavior troublesome (Intensity Scale). It has been widely used in treatment outcome studies for disruptive disorders. It can be used in combination with the Sutter-Eyberg School Behavior Inventory-Revised (SESBI-R), a teacher-report version.

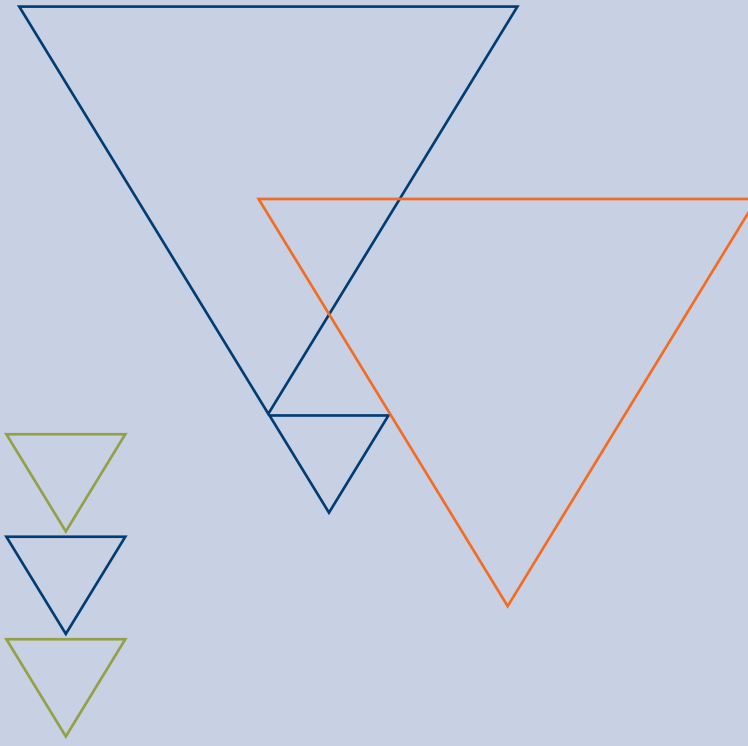
Child Behavior Checklist (CBCL). The CBCL is a 112-item general diagnostic instrument for child behavioral and emotional problems and competencies. Behavioral rating data can be obtained from multiple sources (i.e., child, parent, teacher). The CBCL is available in three versions: parent report (CBCL/6–18, for six- to eighteen-year-olds), teacher report (TRF, for six- to eighteen-year-olds) and adolescent self-report (YSR, for eleven- to eighteen-year-olds). In addition, parent and caregiver and teacher report forms for eighteen-month-olds to five-year-olds are available. The problem behavior items load onto two broad-band scales (Internalizing and Externalizing) and eight narrowband scales (Rule Breaking, Aggressive Behavior, Withdrawn Depressed, Somatic Complaints, Anxious-Depressed, Social Problems, Thought Problems, and Attention Problems).

Behavior Assessment Scale for Children (BASC). The BASC is a diagnostic measure of child and adolescent behavioral adjustment. The BASC is available in three versions: parent report (BASC-PRS), teacher report (BASC-TRS), and child self-report (BASC-SRP). The BASC assesses both child adaptive behaviors and problem behaviors. Three different forms are available depending on age (preschool, child, or adolescent). The BASC-PRS consists of three broad composite scales (Externalizing Problems, Internalizing Problems, and Adaptive Skills) and twelve subscales. The BASC-TRS consists of four broad composite scales (Externalizing Problems, Internalizing Problems, School Problems, and Adaptive Skills) and fourteen subscales. The BASC-SRP consists of three broad composite scales (School Maladjustment, Clinical Maladjustment, and Personal Adjustment).

Targeted Diagnostic Assessment Measures. Not covered in this chapter are diagnostic tools for specific behavioral disorders. These can be found in the accompanying online modules that present information on diagnosis and treatment of an array of behavioral disorders. Some behavioral health conditions are evaluated using standardized scales, while others may rely on a checklist of symptoms derived from the DSM-5-TR (APA, 2022).

Tips and Take-Home Points

- Behavioral problems are prevalent in patients seen in primary care medical practices. Parents frequently seek assistance from primary care physicians for child/adolescent behavior problems.
- Primary care physicians typically use the clinical interview to screen for behavioral health problems, but estimates are that 50 percent to 80 percent of behavioral health disorders are missed through an interview process.
- The use of standardized screening instruments is recommended and can better identify potential behavior problems, patients in need of further diagnosis and treatment, severe mental health issues needing emergency room referral, and problems that can be treated as part of prevention.
- There are a variety of approaches to conducting behavioral health screening, including use of standardized measures at intake, during well child visits, and universal screening for all patient at every visit with a primary care provider.
- Behavioral health screening measures are recommended by the American Academy of Pediatrics, the Health Services and Resources Administration, the Substance Abuse and Mental Health Administration, and the National Center for School Mental Health.



Chapter 10

Diagnostic, Billing, and Insurance Considerations

Healthcare insurers require documentation from behavioral health providers for services to be reimbursed.

Your business arrangement will dictate your billing practices and requirements. Additionally, your state laws and regulations in your state is also important to billing. Regardless of the business arrangement made with a primary care medical practice, procedures for behavioral health billing and reimbursement need to be established. Diagnosis, coding for type and duration of services provided and licensure level are all involved in obtaining reimbursement for behavioral health services. Currently, fee-for-service practices dominate reimbursement within the overall national healthcare system. Due to this emphasis, we focus upon processes required for behavioral healthcare reimbursement using CPT (Current Procedural Terminology) for coding of service descriptions and the ICD-10 (International Classification of Diseases, 10th edition) and DSM (Diagnostic and Statistical Manual of Mental Disorders) of the American Psychiatric Association (APA, 2022) for behavioral health diagnostic classification information. We focus on diagnostic, billing, and insurance considerations for behavioral disorders commonly seen in primary care practices by behavioral health providers. Graduate training programs may, or may not, have covered such topics as the application of Current Procedural Terminology (CPT) service provision codes, diagnostic classifications of behavioral health disorders using ICD-10 or DSM-5-TR, billing, and insurance. For those who have been in practice, this chapter may be somewhat redundant. With a focus specifically upon pediatric integrated primary care, however, this may be a new area or may serve as a refresher if coming from a practice that has primarily served adults.

Fee-for-Service Billing

In the ever-changing world of healthcare insurance, there are ongoing challenges in obtaining reimbursement for all types of healthcare services, both physical and behavioral. Currently in the United States, most billing for healthcare services is done on a fee-for-service basis. In essence, after a medical/behavioral service is provided, a bill is produced based upon the diagnosis of the patient's presenting symptoms and the type of service provided. The patient may then be required to pay a designated co-payment to the provider (depending upon requirements of the insured's policy), a bill is sent to the insurer, the patient's insurance company has an

> Currently, the majority of behavioral healthcare billing is being done on a fee-for-service basis. There is a movement toward "value-based" reimbursement in healthcare that focuses upon quality measures.

agreed-upon discount rate and pays the remainder of the bill up to a certain maximum. The patient and provider then receive an explanation of benefits (EOB) which reports the service provided, any required co-pay and/or deductible, amount of insurance benefit paid to the provider, and any remaining balance due. Based on this information, a bill is then issued by the healthcare provider to the patient for any remaining fees due. Explanations for denials and/or limitations of payment are included in the EOB.

This process can be quite cumbersome, especially in primary care clinics in which there are a variety of insurance companies with differing coverage requirements for patients and families. There also may be significant differences in the payments for services between insurance companies. Having to resubmit bills or appeal denials of payment are common and to be expected, but this can be minimized through appropriate coding, accurate diagnosis, and timely reporting. For example, some policies do not cover certain behavioral health diagnoses, which may only be discovered when the bill is denied. In addition, some policies require a clinician to make a request to get authorization for diagnostic testing before a psychological evaluation can be provided. The behavioral health provider is required to make the case as to why the testing is necessary and how the information will inform treatment. These examples demonstrate the non-uniformity of billing and reimbursement processes between insurers. Billing clerks can be of great help in advising clinicians about the procedures required by various insurance providers.

Most primary care medical practices or healthcare systems have personnel specifically dedicated to the billing process who work closely with health insurance companies. Behavioral health providers who rent space or contract with a medical practice typically assume responsibility for billing and collections. Clinicians can master this process, but may require assistance from outside billing agencies (charging anywhere from 6 percent to 10 percent of collected fees or on a per bill submitted basis.). For new behavioral health clinicians or primary care practices that are not familiar with BH billing nuances, we suggest use of a billing agency for reimbursement procedures initially. While the fee-for-service billing system has been criticized over the years, the primary advantage for providers is that the harder a clinician works in providing services, the higher the income level is for the provider. For the same reason, a primary critique of the fee-for-service system is that it tends to reinforce the volume of patients served and not the quality of care provided.

Value-Based Reimbursement

An alternative to the fee-for-service environment that is currently becoming fashionable is “value-based” reimbursement. One example of value-based reimbursement is the ACO (Accountable Care Organization). An ACO covers the entire spectrum of healthcare provision ranging from outpatient primary care, specialty medical care, and inpatient hospital care and includes obstetrics, surgeries, intensive care, emergency departments, psychiatric services, speech and hearing, physical therapy, etc. The objective behind the ACO is to create a healthcare organization that can meet all the healthcare needs of a population of patients ranging from maternity through geriatric care. In the ACO model, billing does not occur on a

fee-for-service basis. Rather, there is regular up-front "prospective" payment to the ACO with the amount of funding based upon a "per member, per month" formula. Payment is based upon the number and severity level of patients served in the practice. While documentation of diagnosis and treatment of physical and mental health disorders is still required, payment to individual providers is not simply based upon numbers of services delivered but theoretically is related to the value and quality of care provided.

The objective behind the ACO is to create a healthcare organization that can meet all the healthcare needs of a population of patients ranging from maternity through geriatric care.

A fully functioning ACO is expected to provide all healthcare services required for its patient population and meet certain standards, such as a designated percentage of pediatric patients being vaccinated each year for diphtheria, polio, and tetanus; reductions in rehospitalizations following surgery; percentages of enrolled patients seen for annual checkups; patient satisfaction measures; etc. Based upon meeting these designated value standards, the ACO is entitled to keep all the funds collected prospectively from insurers, Medicaid, and Medicare. By way of example, in one of our local ACO systems, the organization generated an excess of $1.5 million over its operating expenses. Profits were shared among its more than two hundred providers as a bonus at the end of the calendar year. Interestingly, an analysis conducted by this ACO's administration found that one of its most expensive but potentially controllable costs was related to primary care patients being referred to hospital emergency departments for assessment of risk for self-harm behaviors.

At the time that this manual was written, there were several value-based reimbursement "pilot projects" being conducted across the country. Some projects addressed overall healthcare, but others focused on specific areas such as mental health services. In Minnesota, for example, an interagency collaborative was formed to provide all behavioral health services for children and adolescents who have Medicaid coverage in a designated geographic area. In this pilot project, state government contracted directly with this semi-ACO organization of behavioral health agencies. This arrangement omitted the typical profit margin generated by commercially managed care Medicaid insurance companies, thus potentially saving millions of dollars. Another example of a value-based reimbursement program was the CPC+ (Comprehensive Primary Care Plus) program of CMS (Centers for Medicare and Medicaid Services) which was piloted in eighteen states and provided up-front prospective funding to individual and group primary care medical practices that agreed to meet specific standards, including some form of integration of behavioral health into primary care clinics. If standards were met, providers could keep all the funding awarded. If not met, however, practices were required to refund portions of the prospective payment to the funding agency (in this case, to Medicare).

The movement toward value-based reimbursement has been slow to be implemented, and there are various interpretations across states. A major issue impeding value-based reimbursement is determining what measures really assess value and quality of care. Currently, fee-for-service practices continue to dominate reimbursement within the overall national healthcare system. Due to this emphasis, we will focus upon processes required for behavioral healthcare reimbursement using CPT (Current Procedural Terminology) for coding of service descriptions and the ICD-10 (International Classification of Diseases, 10th Edition) and DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders) of the American Psychiatric Association (APA,2022) for behavioral health diagnostic classification information. The ICD-10 and DSM-5-TR provide behavioral diagnostic categories that are largely, but not always, concordant. These three documents provide guidance for billing within the integrated pediatric primary healthcare environment.

CPT Codes in Pediatric Integrated Primary Care

CPT codes have been developed for all types of healthcare services, physical and behavioral. We will concentrate our discussion here on the typical codes used in addressing the common behavioral health disorders of children and adolescents that are prevalent within the primary care medical practice setting. CPT behavioral health codes are designed for use by licensed providers (psychiatrists, psychiatric nurse practitioners, psychologists, social workers, marriage and family therapists, and counselors). Some codes involving prescription of psychotropic medications or medication reviews can only be used by physicians, nurse practitioners, physicians' assistants, psychiatrists, or psychiatric nurse practitioners. Still other codes, such as for psychological testing, can only be used by licensed psychologists. In some states, diagnostic evaluations can only be billed under a physician, psychiatrist, psychiatric nurse, psychologist, or independently licensed clinician with a master's degree.

> CPT codes are not only specific to the type of service provided but also reflect time spent with patients.

At the end of this chapter, there is a sample table of one state's billable CPT code for use in Community Health Centers. This table was generated by SAMHSA (Substance Abuse and Mental Health Services Administration). The graphic describes services and CPT billing codes that can be used for mental health, telehealth, and substance abuse services and diagnosis. The table also identifies service providers allowed to use various codes and whether services are reimbursable. For example, for patients covered by Medicaid/Medicare, medical evaluation codes can only be used by physicians, nurse practitioners, and physicians' assistants. Mental health services can be reimbursed to psychiatrists, psychiatric nurse practitioners, psychologists, licensed mental health practitioners (social workers, marriage and family therapists, and counselors) and in some states, provisionally licensed behavioral health providers. See SAMHSA's Center for Integrated Care Services for a listing of codes and services used in each state.

A more recent and additional set of approved billing codes are the Health and Behavior Assessment and

Intervention codes (H&B codes) available from the Center for Medicaid/Medicare Services. These codes can be used by physicians and some behavioral health providers when the primary condition being treated is medical, the patient has behavioral health concerns related to the medical condition, but the symptoms do not warrant a psychiatric diagnosis. For example, if the patient's primary diagnosis is medical (epilepsy), but the patient is having difficulty with medication adherence, a H&B code could be used to bill for services related to medication management strategies. By contrast, a physically healthy patient presenting with elevated levels of anxiety would be treated using a mental health code if there is no apparent physical condition causing the anxiety or stress. Approval for use of the H&B codes varies from state to state, and you should check with the local Medicaid office to see if this code is approved in your state's Medicaid plan and if there are limitations as to which behavioral health professions can use these codes.

CPT codes are not only specific to the type of service provided but also reflect time spent with patients. Some codes are untimed (such as for diagnostic evaluation intake sessions) but the majority of behavioral health codes correspond to the amount of time spent in delivering various levels of behavioral healthcare. Below is a simple listing of the codes typically used in integrated pediatric practice.

Table 2. Level of Service/CPT Billing Codes

CPT BILLING CODES	SERVICE
90791	Integrated Biopsychosocial Assessment (i.e., Intake Evaluation)
90832	Individual Psychotherapy, 30 minutes (with/without family present), 16 to 37 minutes session time
90834	Individual Psychotherapy, 45 minutes (with/without family present), 38 to 52 minutes session time
90837	Individual Psychotherapy, 45 minutes (with/without family present), 53 minutes or longer session time **UBH requires prior authorization.
90839	Psychotherapy for crisis; 30 to 74 minutes
90840	Psychotherapy for crisis; each additional 30 minutes following use of 90840 code
90846	Family Psychotherapy, without the patient present **Some plans do not cover this code.

Table 2. continued

CPT BILLING CODES	SERVICE
90847	Family Therapy, minimum of 26 minutes with patient and at least one family member
90849	Multi-Family Group Psychotherapy, non-time-based code (All insurance companies except BCBS)
90853	Group Psychotherapy, non-time-based code (3 to 12 participants) (All insurance companies except BCBS)
96130 (base code, 1 hour) 96131 (each additional hour unit)	Psychological Testing evaluation services code *Must meet minimum time of 31 minutes.
96136 (base code, 30 minutes) 96137 (add on code, 30-minute units)	Test Administration and Scoring Code by Qualified Health Professional (i.e., person credentialed with insurance company to bill the service, such as an LP) *Must meet minimum time of 16 minutes.
96138 (base code, 30 minutes) 96139 (add on code, 30-minute units)	Test Administration and Scoring Code by Technician (i.e., person credentialed with insurance company to assist QHP (Qualified Health Professional) with administration, such as PLMHP (Provisional Licensure as Mental Health Practitioners), LMHP (Licensed Mental Health Practitioners. *Must meet minimum time of 16 minutes.
GT Modifier	Social Skills Group Therapy (2 or more patients face-to-face)
97154	Social Skills Group (parent/caregiver group) Family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.
97157	Functional behavioral assessment (per 15 minutes) – Can be billed by BCBA, PLP, LIMHP, LP
97151	Functional behavioral assessment (per 15 minutes) – Can be billed by BCBA, PLP, LIMHP, LP

The following page provides a sample of billing codes that can be used by different types of behavioral health providers. The table also provides information according to the profession of providers licensed to provide healthcare coverage in the State of Nebraska. It is recommended that you, as a behavioral health provider, create your own table of billable codes from insurers that are common to your primary care practice. The table below is meant to provide a sample of billing codes for non-prescribing behavioral health providers including psychologists, social workers, counselors, and marriage and family therapists. Titles of the various types of providers are specific to Nebraska and may have different labels in other states.

LP – Licensed Psychologist

PLP – Provisionally Licensed Psychologist

LIMHP – Licensed Independent Mental Health Practitioner

LMHP – Licensed Mental Health Practitioner

PLMHP - Provisionally Licensed Mental Health Professional

Note: In Nebraska, master's level behavioral health professionals (social workers, marriage and family therapists, and mental health counselors) are licensed under an umbrella category of Mental Health Professional. Upon graduation from a training program, master's level behavioral health providers become Provisionally Licensed Mental Health Practitioners until they have achieved three thousand hours of postgraduate supervision. Providers with master's degrees then become Licensed Mental Health Professionals. With extra training and work experience with severely mentally ill patients, master's level providers can become Licensed Independent Mental Health Professionals. Mental health status examinations and mental health diagnoses can only be provided by Licensed Psychologists, Provisionally Licensed Psychologists, and Licensed Independent Mental Health Practitioners (in addition to the prescribing medical professionals listed above). It is beneficial to be knowledgeable of the scope of practice statutes for your discipline in the state(s) in which you are practicing or plan to practice. These documents can usually be obtained from the State Licensing Board or Department of Health.

Table 3. Mental Health Codes—Level of Services Able to Bill by Licensure Type and Insurer in Nebraska

INSURANCE	CODE	LP	PLP	LIMHP	LMHP	PLMHP
United HCCP WellCare Total Care	90791	x	x	x		
	90832/34/37/47	x	x	x	x	x
	96130/1 96136/7 96138/9	x	x			
	H0031-AH H0031-52	x		x		
Amerigroup UHC River Valley	90791	x		x	x	
	90832/34/37/47	x		x	x	
	96130/31/36/37/38/39	x				
BC/BS NE	90791	x	x	x	x	x
	90832/34/37/47	x	x	x	x	x
	96130/31/36/37/38/39	x	x	x	x	
Blue Card	90791	x	x	x	x	x
	90832/34/37/47	x	x	x	x	x
	96130/31/36/37/38/39	x				
Cigna	90791	x		x	x	
	90832/34/37/47	x		x	x	
	96130/31/36/37/38/39	x				
Medicare / Golden Rule	90791	x		*	*	
	90832/34/37/47	x		*	*	
	96130/31/36/37/38/39	x				

Note: **PLP: Can bill Medicaid for initial and return appointments. Annual assessment for Medicaid must be completed by an LP. LMHP: Can bill any insurance company credentialed with for services marked with an X. An LP must complete intake assessments (90791) for Medicaid patients. Additional limitations for psychological testing vary by insurance company (see table). PLMHP: Can bill Medicaid return and Blue Cross Blue Shield intake and return appointments, if credentialed with these insurance companies.

Table 3. continued

INSURANCE	CODE	LP	PLP	LIMHP	LMHP	PLMHP
MHNet	90791	x		x	x	
	90832/34/37/47	x		x	x	
	96130/31/36/37/38/39	x				
TriCare	90791	x		x	x	
	90832/34/37/47	x		x	x	
	96130/31/36/37/38/39	x				
UBH / UMR	90791	x		x	x	
	90832/34/37/47	x		x	x	
	96130/31/36/37/38/39	x				
Value Options	90791	x				
	90832/34/37/47	x				
	96130/31/36/37/38/39	x				

Note: **PLP: Can bill Medicaid for initial and return appointments. Annual assessment for Medicaid must be completed by an LP. LMHP: Can bill any insurance company credentialed with for services marked with an X. An LP must complete intake assessments (90791) for Medicaid patients. Additional limitations for psychological testing vary by insurance company (see table). PLMHP: Can bill Medicaid return and Blue Cross Blue Shield intake and return appointments, if credentialed with these insurance companies.

Behavioral Health Diagnoses

The process for arriving at a behavioral health diagnosis mirrors diagnostic procedures used in the practice of medicine. Patients see a provider, are evaluated for type and number of symptoms corresponding to specific health conditions and are diagnosed based upon the match between symptoms and diagnostic classifications. Medical diagnoses frequently require lab tests (such as urinalysis, platelet count, cholesterol level, DNA analysis, etc.), performance measures (such as electrocardiogram stress tests, audiology examination, memory tests, etc.), body scans (such as X-rays, CT scans, MRIs, PET scans, etc.) or invasive procedures (such as biopsies, cystoscopies, angiograms, etc.). Diagnoses are assigned based upon test results and reports of symptoms from patients. The ICD-10 (International Classification of Diseases and Related Health Problems, 10th Edition), published by the World Health Organization, has over 69,000 diagnostic codes in three volumes (doubling the number from ICD-9). The ICD-10 CM was implemented for usage in the United States in 2013. The ICD-10 has twenty-two chapters, with the fifth chapter covering mental/behavioral diagnoses.

To align with medical diagnostic procedures, the American Psychiatric Association has developed a series of Diagnostic and Statistical Manuals of Mental Disorders, or DSMs. Unlike many physical disorders that have biological markers that define the respective diagnosis, symptoms and classifications of mental health disorders were determined by workgroups of “experts” in their respective behavioral/mental

health fields. Teams generally consisted of panels of psychiatrists and, to a limited degree, psychologists. The DSM-5-TR (APA, 2022) is divided into twenty-two separate categories covering such conditions such as neurodevelopmental disorders, depressive disorders, anxiety disorders, OCD and related disorders, eating and feeding disorders, elimination disorders, learning disorders, sexual dysfunctions, etc. Practicing behavioral health clinicians should have copies of the most current DSM for reference. The remainder of this chapter will focus upon the most common pediatric behavioral health diagnostic categories typically presenting in primary care practices.

Why Diagnose?

There has been an ongoing controversy in behavioral health over the need to place diagnostic labels on patients. Some clinicians take the position that behavioral problems are inadequate or inappropriately learned responses to stressors of the human condition. Others argue that placing a diagnosis on a patient (especially a child or teenager) labels that individual throughout life. Still others claim that having a diagnosis often excuses unacceptable behavior due to the mental condition. Others suggest that diagnoses inappropriately blame individuals for adaptive responses to maladaptive environmental and social conditions (i.e., social determinants of health). On the other side of the argument, clinicians point out that there are many commonalities across diagnostic categorizations and that registries of behavior disorders (such as depression) should be established to assist clinicians in addressing patient populations with common diagnostic characteristics. Others indicate that behavioral measures are improving and that diagnostic categories should have corresponding treatment pathways or protocols that are evidence-based and standardized.

Irrespective of this controversy, the current overriding position of insurers and the Centers for Medicaid and Medicare involves fee-for-service reimbursement with required diagnosis and documentation of the type and time of service delivery. Insurers require that provision of behavioral health services be justified based on “medical necessity.” Behavioral health diagnostic codes, derived from specific lists of related symptoms, justify medical need for services. A diagnosis is needed for a justification for provision of treatment.

Common Diagnostic Categories for Child and Adolescent Behavior Disorders

One national study has indicated that 16.5 percent of children have at least one mental health condition, with only 49.4 percent receiving treatment from a qualified and licensed behavioral health provider (Whitney & Peterson, 2019). Unfortunately, this means that over half of those with one mental health condition do not receive behavioral health treatment. Online HealtheKnowledge modules cover common childhood behavior disorders. In these modules, symptoms for diagnosis are presented in detail along with behavioral treatment protocol suggestions for each condition. The remainder of this section lists applicable behavioral health diagnoses based upon DSM-5TR (APA, 2022 categorizations (most of which are in line with ICD-10). It is recommended that clinicians maintain a simple diagnostic notepad or smartphone app consisting of a list of diagnoses and related symptoms. This can assist in review of symptoms with patients and families as well as justifying medical necessity and behavioral diagnosis. Physicians frequently have notebooks or smartphone apps that cover many categories of physical health disorders and related medications, and this procedure can similarly be used in providing diagnostic prompts for behavioral health clinicians.

Behavioral health diagnoses for pediatric populations served in primary care practices are not well represented in all twenty-two classifications of the DSM-5-TR. The following table is a brief list of diagnoses that fit under relevant DSM-5-TR classifications. It should be noted that the majority of diagnoses typically used in primary care practice are Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Sleep Disorders, Anxiety Disorders, and Depressive Disorders.

Table 4. Level of Service/CPT Billing Codes

NEURODEVELOPMENTAL DISORDERS	
319	Intellectual Developmental Disorder[1]
299	Autism Spectrum Disorder – specify level of severity, required supports, and any comorbid intellectual disability
314.00	Attention Deficit Hyperactivity Disorder – Inattentive type
314.01	Attention Deficit Hyperactivity Disorder – Hyperactive/Impulsive type
314.01	Attention Deficit Hyperactivity Disorder – Combined type
315.00	Specific Learning Disorder[2] – specify impairment in reading, written expression, or mathematics
DEPRESSIVE DISORDERS	
296.99	Disruptive Mood Dysregulation Disorder
311	Unspecified Depressive Disorder
293.83	Depressive Disorder Due to Another Medical Condition
ANXIETY DISORDERS	
309.21	Separation Anxiety Disorder
312.23	Selective Mutism
300.29	Specific Phobia – specify if for fear of animals, natural environment, injection, situational, or other Generalized Anxiety Disorder
300.00	Generalized Anxiety Disorder
OBSESSIVE-COMPULSIVE AND RELATED DISORDERS	
300.3	Obsessive-Compulsive Disorder – specify if tic-related
312.29	Trichotillomania
TRAUMA AND STRESSOR-RELATED DISORDERS	
313.89	Reactive Attachment Disorder
308.3	Acute Distress Disorder
309	Adjustment Disorder – specify if with depressed mood, anxiety, mixed anxiety and depression, disturbance of conduct, mixed disturbance of emotions and conduct or unspecified
309.9	Unspecified Trauma and Stressor Related Disorder

Note: Some organizations may require providers to use ICD-10 codes.
[1]Usually an existing diagnosis provided through IQ testing by a school or licensed psychologist
[2]Usually derived from testing done by certified school personnel or a licensed psychologist

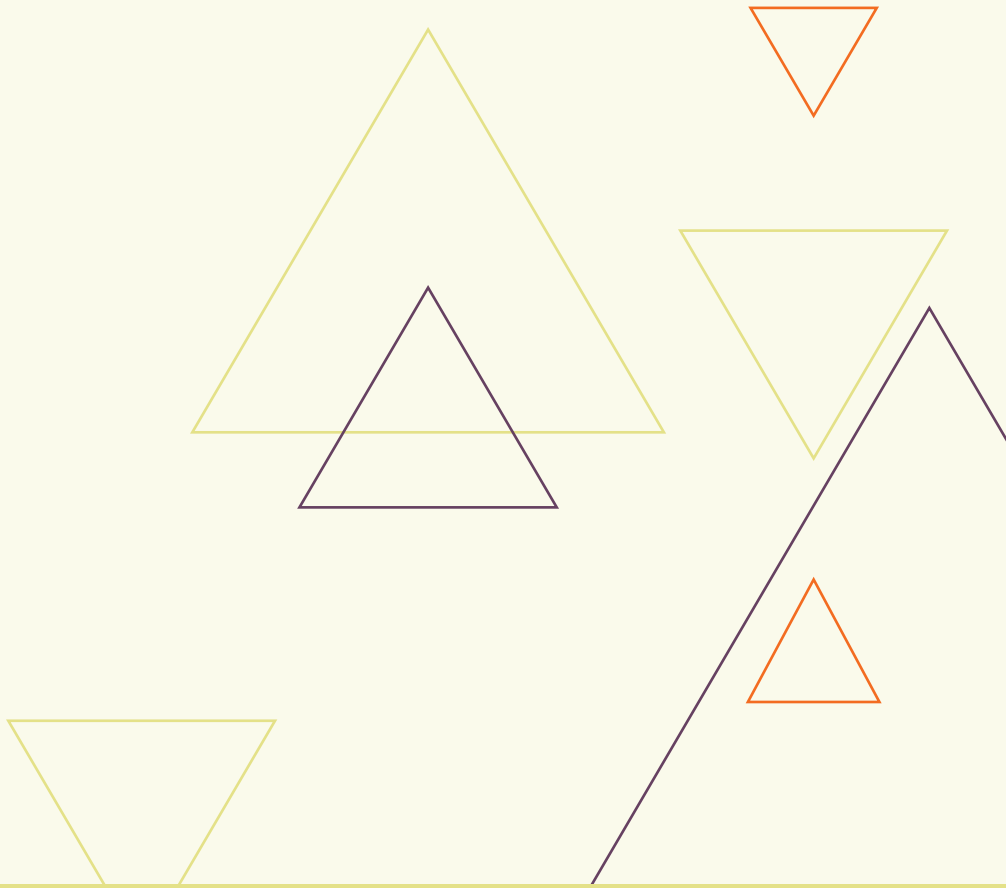
Table 4. continued

SOMATIC SYMPTOM AND RELATED DISORDERS	
300.82	Somatic Symptoms Disorder
FEEDING AND EATING DISORDERS	
307.1	Anorexia Nervosa
307.51	Bulimia Nervosa
307.50	Unspecified Feeding and Eating Disorder
ELIMINATION DISORDERS	
307.6	Enuresis – specify whether nocturnal or diurnal or both
307.7	Encopresis – specify whether or not with constipation and overflow
SLEEP-WAKE DISORDERS	
307.47	Nightmare Disorder
DISRUPTIVE, IMPULSIVE CONTROL, AND CONDUCT DISORDERS	
313.81	Oppositional Defiant Disorder – specify if mild, moderate, or severe
312.34	Intermittent Explosive Disorder
312.81	Conduct Disorder – specify if childhood or adolescent onset type
SUBSTANCE RELATED AND ADDICTIVE DISORDERS	
305.00	Alcohol Use Disorder – mild
303.89	Alcohol Use Disorder – specify if moderate or severe
305.20	Cannabis Use Disorder – mild
304.30	Cannabis Use Disorder – specify if moderate or severe
305.90	Inhalants Use Disorder – mild
304.60	Inhalants Use Disorder – specify if moderate or severe
305.50	Opioid Use Disorder – mild
304.00	Opioid Use Disorder – specify if moderate or severe
305.70	Stimulant Use Disorder – mild; specify if amphetamine, cocaine, or other

[1]Usually an existing diagnosis provided through IQ testing by a school or licensed psychologist
[2]Usually derived from testing done by certified school personnel or a licensed psychologist

Tips and Take-Home Points

- Billing for behavioral health services require a credentialed provider, a diagnosis from the ICD-10 or DSM-5-TR, (APA, 2022) and a CPT code.
- CPT codes are specific to behavioral disorders, the credentials of the providing practitioner, type of service provided, and the length of the session.
- The International Code of Diseases (ICD-10) and the Diagnostic and Statistical Manual of the American Psychiatric Association DSM-5-TR provide diagnostic codes of more than one thousand behavioral conditions.
- Common behavioral diagnoses used in treating pediatric patients include twelve categories in which neurodevelopmental disorders, depressive disorders, anxiety disorders, sleep disorders, trauma and stress disorders, and disruptive disorders are most prevalent.
- Most primary care practices have staff specifically assigned to coding and billing duties that can be helpful with behavioral billing. If not available, there are professional billing agencies that can be contracted for a small percentage of collections.



Chapter 11

The Electronic Health Record (EHR)

The content of this chapter is intentionally brief based upon the number and variety of electronic health record (EHR)—also known as the electronic medical record (EMR)—systems that are currently in use within healthcare systems, hospitals, and primary care practices.

Each system has its own nuances for data entry, drop-down menus, smart phrases, reporting standards, and IT rules. Since there are so many variations of EHR systems, it would be impossible to provide direction for the use of each. Implementation of electronic medical records within a large healthcare system can quite literally cost millions of dollars for software and installation. Training for staff to implement an EHR can take days to weeks for mastery. Alternatively, we focus on the topics and headings that are common to healthcare and provide some recommendations and tips for usage based upon our experiences in the field.

Background of the EHR

In the past, health records were generally put into paper patient files. Doctors' notes for an acute episode could be as brief as one sentence in a patient's chart. On the other hand, for individuals with chronic medical conditions, written files could literally be several inches thick with results from test upon test, repeated treatment session results, interventions, progress, etc. Health records between specialists from different hospital systems were not openly shared, sometimes leading to prescriptions of medications for one condition that might be contraindicated for treatment of another disorder for which a patient was being treated. Additionally, being in a mobile society today, changes in positions, insurers, and healthcare systems have become common. Getting copies of patient healthcare records from a former healthcare provider or system could take weeks. Consequently, much duplication, unnecessary costs, and inefficient patient care were common within the overall healthcare system.

We focus on the topics and headings that are common to healthcare and provide some recommendations and tips for usage based upon our experiences in the field.

The first attempts to computerize medical records occurred at the Mayo Clinic in the 1970s. It was not until the age of the internet, however, that the concept of a single portable "electronic health record" for

every patient was conceptualized. In 2004, President George W. Bush created the Office of the National Coordinator for Health Information Technology (Becker's Hospital Review, 2015), which outlined a plan to ensure that most Americans had electronic health records designed to

- share information privately and securely with the patient's authorization
- help healthcare quality, prevent medical errors and reduce paperwork
- improve administrative efficiencies and healthcare quality

A single EHR for every patient was proposed that would capture, record, and maintain all of a patient's vital healthcare information, including diagnoses, test results, medications, progress, current status, treatment recommendations, etc. Information from the EHR would be instantaneously available to new health providers, such as in the case of a hospital emergency visit while a patient was away from home on vacation. Such information would be invaluable in light of a patient being incapacitated and unable to relate current conditions or prescribed medications. While the concept of a common healthcare record was laudable, getting major changes within the huge overall healthcare system has been difficult. To date, while the majority of healthcare systems have adopted electronic record-keeping systems, many of the EHR systems cannot readily "talk" to one another and share critically valuable patient health information. More and more advances are being made to solve these problems, but the original concept is yet to be realized.

A major difficulty in record-keeping for behavioral healthcare is the fact that the majority of large EHR systems did not originally include behavioral health as part of the overall electronic health record. As a result, enterprising companies have developed separate electronic behavioral health record-keeping systems. Many of these newer EHRs are designed to interface between behavioral and physical health records in hospitals and large healthcare systems. Large healthcare systems' EHRs may or may not communicate well with the electronic EHR programs found in behavioral health agencies or independent primary care clinics. In any case, electronic health records are here to stay and can be very useful in communication between medical and behavioral health professionals in integrated primary care practices. To be a truly integrated primary care practice, we feel it is imperative to have one EHR system in the practice that contains health care information of both a physical and behavioral nature.

Documentation

Insurance companies require specific information to be documented in the medical record from each clinical encounter. Clinicians should use the templates common to their collaborating primary care practice, if at all possible, to ensure compliance with insurance regulations and for communication with other healthcare providers in the practice. Documentation standards for behavioral health billing typically request the following information for each patient encounter.

Name:	
Medical Record Number	
Date of Birth:	
Insurance ID Number:	
Date of Service:	
Location (Clinic Name):	
Service:	
Time: Start and Stop	
Type of Session:	
Provider Name:	

Initial Intake Session Report

Based upon most insurers' guidelines, the following documentation (in addition to that listed above) meets requirements for most governmental (Medicaid/ Medicare) and commercial carriers.

- Chief complaint
- Referral source
- History of present illness
- Past behavioral health history
- Relevant medical history
- Social and family history
- Mental status examination results
- Formulation/prognosis
- Treatment plan
- Assessment of patient's ability to adhere to the treatment plan
- Diagnosis
- Who was present in the session (this is to include the billing provider), e.g., the clinicians present/ participating in patient's care today plus mother, father, child/adolescent patient, siblings, and other caregivers
- Signature of the service provider

Progress Notes (SOAP Notes)

SOAP notes are common to healthcare records and the acronym SOAP stands for:

- Subjective report of the patient about symptoms, improvements, progress or lack thereof,
- Objective information or data obtained from sources such as test results, lab findings, school reports, etc.,
- Assessment of the effectiveness of the treatment being implemented, and
- Plan for continuation, monitoring, and/or changing the treatment plan as needed.

Based upon most insurers' guidelines, the following information will typically meet documentation requirements for most governmental and commercial carriers:

- Type of session being provided (individual session, family session, etc.).
- Target symptoms
- Pertinent risk factors (e.g., suicidal ideation)
- Progress (or regression) toward achievement of treatment goals
- Diagnosis (should match diagnosis from intake report or indicate new diagnosis based on current or new info)
- Individuals present in the session (provider, patient, family members, etc.)
- SOAP note information
- Signature of provider
- NOTE: If group or multiple-family group sessions, separate notes for each session should be reported.

Requests for Information

In general, patients and insurance companies have access to information within the patient medical record. Providers should be aware that entered information is open for review by a patient and should avoid any language that might be derogatory about the patient or other family members. There are occasions when information is being requested by another provider (such as a neurology specialist treating epilepsy). Conversely, a behavioral health provider may need information from a former therapist or from an agency in another town or from a school district.

To provide written records to a third party, an authorization to release patient records must be signed by the patient (if of the age of majority) or the patient's legal guardian. Similarly, when a behavioral health provider requests information from other healthcare providers, agencies, or schools, an authorization should be signed by the patient or legal guardian.

Grounds for Denial

Under very limited circumstances, a clinician may deny an individual's request for access to all or a portion of the patient health information (PHI) requested. A patient has a right to have the denial reviewed by a licensed healthcare professional—designated by the clinician—who did not participate in the original decision to deny.

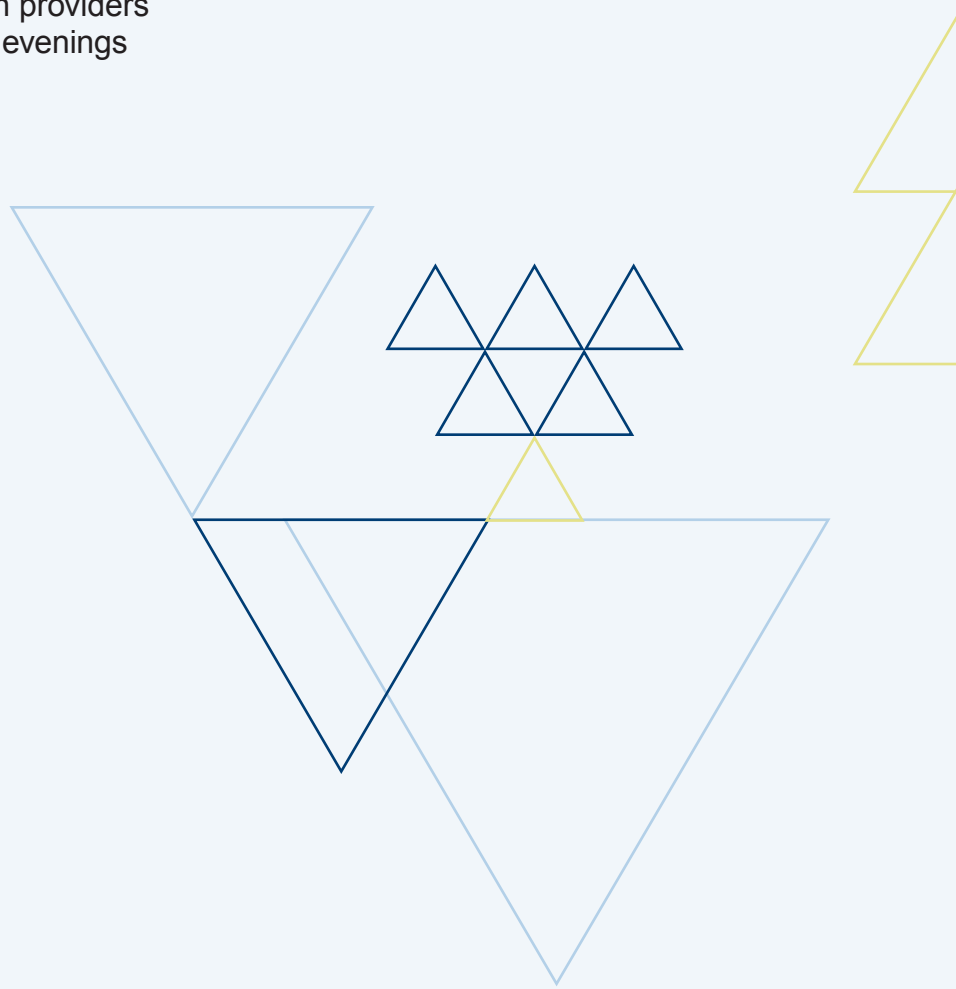
Reviewable grounds for denial. A licensed healthcare professional has determined in the exercise of professional judgment that:

- The access requested is reasonably likely to endanger the life or physical safety of the individual or another person. The grounds for denial do not extend to concerns about psychological or emotional harm (e.g., concerns that the individual will not be able to understand the information or may be upset by it).
- The access requested is reasonably likely to cause substantial harm to a person (other than the clinician) referenced in the PHI.
- The provision of access to a personal representative of the individual that requests such access is reasonably likely to cause harm to the individual or another person.

Clinicians may not require an individual patient to provide a reason for requesting access to his or her health information. In addition, a clinician or practice may not deny access to the patient's health information because a business associate of the clinic, rather than the clinic itself, maintains the health information record requested by the individual. For example, when the health information record is maintained by the clinic's parent healthcare system or is maintained by a record storage vendor off-site.

Tips and Take-Home Points

- Charting in the patient record needs to be done in a timely manner. It is easy to let required report writing build into an insurmountable mass. It is best if charting, especially for progress reports, can be generated the same day as service delivery.
- Keep in mind that your performance on this task will be judged by other members of the primary care practice team.
- Try to reserve some brief times during the day (most frequently after the session) for report writing. Non-adherence to this guideline generally leads to what is referred to as “pajama time” during which providers catch up on reports during their evenings or personal time.
- Develop “smart phrases” or “shortcuts” for your reports. Most EHRs have the capacity to create such things as drop-down menus of phrases or sentences that are common to many conditions or reports. This can greatly reduce data entry and/or dictation (if using systems such as Dragon Speak).
- Above and beyond required entries into the Electric Health Record, a simple note or verbal report to the referring physician within their primary care practice is advisable. Most physicians simply want to know if their patients are being cared for and this greatly enhances communication within the practice.



Chapter 12

Working in the Medical Clinic—Terminology

For anyone new to working in the medical field, there are literally thousands of medical terms describing diseases, body parts, treatments, medications, etc.

Within the field of behavioral/mental health alone, more than one thousand terms ranging from abulia (lack of motivation) to zygote (fraternal versus identical twins) are commonly used (APA, 2023). This chapter provides basic exposure to the medical terminology commonly encountered within a pediatric primary care clinic. A second goal is to make trainees aware that many physical health disorders have coexisting behavioral symptoms. For example, individuals with traumatic brain injury may display symptoms of agitation. The treatment of ADHD with stimulant medications may produce symptoms of insomnia, and patients with epilepsy have a higher incidence of depression than the general public.

Part of this chapter will be a refresher of your Biology 101 coursework. The chapter is organized to provide basic terminology related to:

1. Anatomy of the human body
2. Body systems – adapted from U.S. National Institutes of Health, National Cancer Institute (n.d.a, n.d.b, n.d.c, n.d.d, n.d.e, n.d.f, n.d.g, n.d.h, n.d.i, n.d.j, n.d.k,)
3. Medical professions/specialties – adapted from Association of American Medical Colleges, (n.d.) and Intercostal Medical Group, (2022)
4. Medical prefixes – adapted from National Cancer Institute (n.d.), Nelson & Greene (2021) and University of Central Florida Student Academic Resource Center (n.d.)
5. Medical suffixes – adapted from Nelson & Greene (2021) and University of Central Florida Student Academic Resource Center (n.d.)
6. Medical dictionary descriptions – adapted from Harvard Health Publishing (2011a, 2011b, 2011c), Medline Plus (n.d.a, n.d.b) and National Cancer Institute (n.d.)
7. Common child-adolescent medical conditions presenting in primary care – adapted from Boyd (2023), Bush (2023), Cleveland Clinic (2023), Fried (2022), Mayo Clinic (2017, 2020, 2021, 2022, 2023) and National Center for Immunization and Respiratory Diseases (2022, 2021)

Anatomy of the Human Body

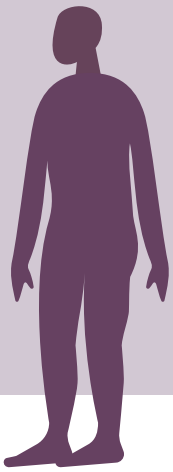
Abdominal – abdomen

Cranial – skull

Digital – fingers and toes

Femoral – thigh

Gluteal – buttocks



Inguinal – groin

Lumbar – lower back

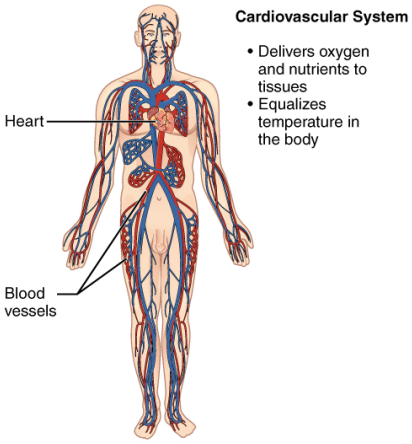
Mammary – breasts

Nasal – nose

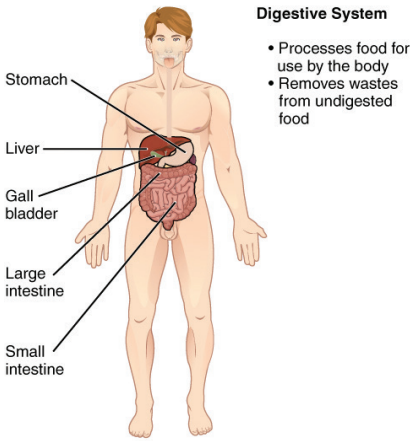
Thoracic – chest

Body Systems

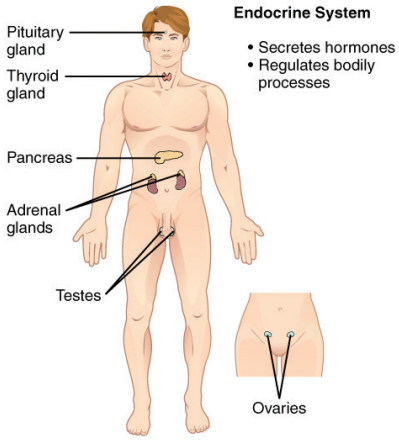
Specialty healthcare providers are generally categorized according to the various body systems upon which they have focused. For our purposes, we briefly discuss the eleven human body systems.



Cardiovascular system – This system consists of the heart, the muscle which pumps blood, and the blood vessels, which circulate blood throughout the body.

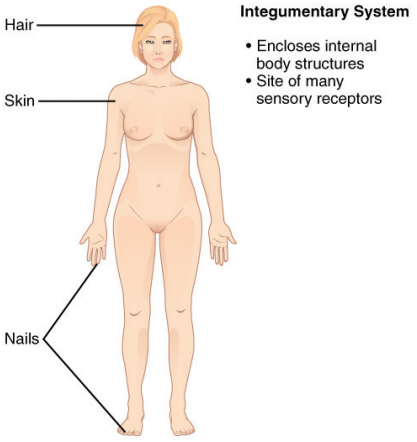


Digestive system – This system is comprised of a long continuous duct which extends from the mouth to the anus. The function of the digestive system is to absorb food and fluids.

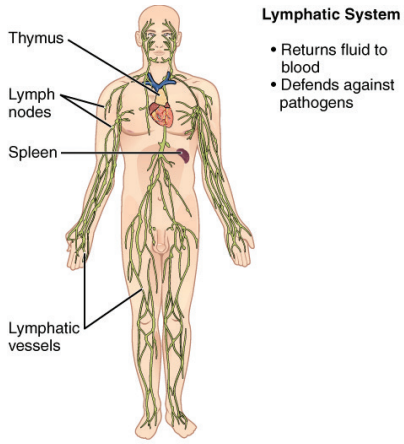


Endocrine system – The endocrine system functions to secrete hormones. Hormones travel throughout the body, via the bloodstream, sending chemical messages that regulate body functions such as metabolism and growth.

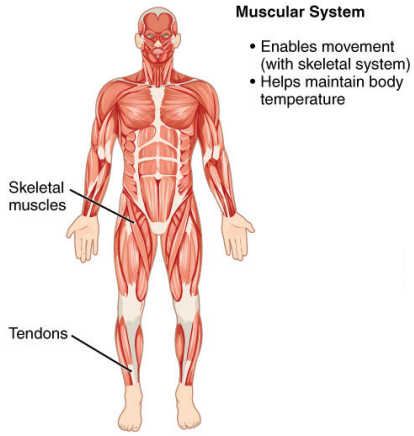
Note: The anatomical figures above are attributable to: By Connexions - http://cnx.org, CC BY 3.0, https://commons.wikimedia.org/w/index.php?curid=29624318o.



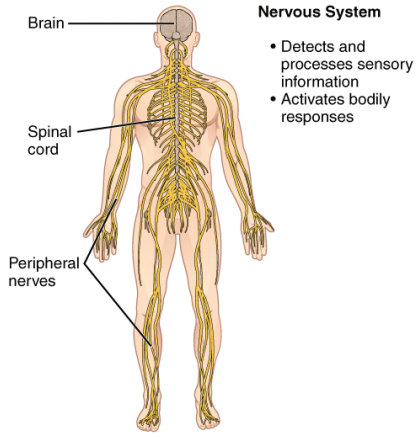
Integument system – The integument system is also known as the skin. Properly functioning skin receives sensory information, helps control body temperature, and protects the body. Together with sunlight, the skin also helps generate vitamin D.



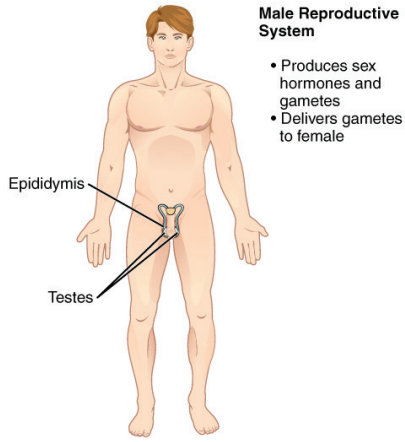
Lymphatic and immune system – The primary function of the immune system is to defend the body. It filters and removes invading organisms in order to prevent disease



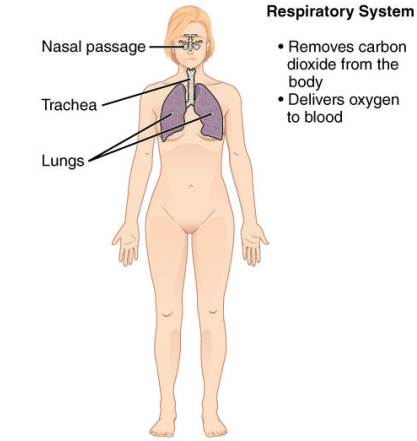
Muscular system – The contraction of muscle cells against bones is what allows the body to move.



Nervous system – The nervous system is where sensory information is processed, and where learning and cognition occur. The spinal cord and brain are the major components of this system.



Reproductive system – The reproductive system allows for procreation. Ovaries and testes produce the eggs and sperm, as well as hormones that function in the development of the reproductive system and sexual characteristics.



Respiratory system – The respiratory system provides oxygen to all organs and removes the waste products from the body. The primary components of the respiratory system are the lungs and trachea.

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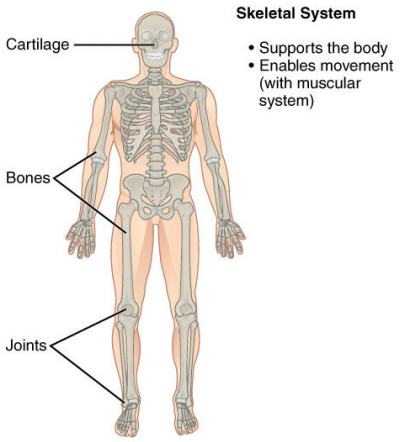

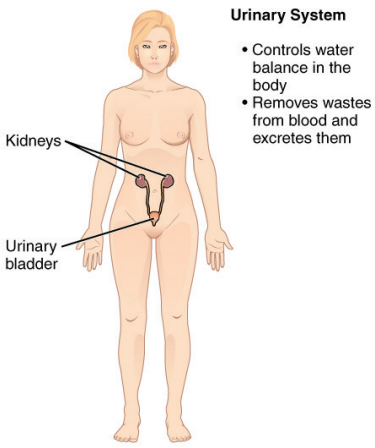

Skeletal system – The skeletal system, which includes bones, tendons and other supportive tissues, protects the body's internal organs and anchors muscles to allow them to move the body.

Urinary system – The urinary system's role is to regulate the body's fluid levels. The kidneys filer out waste products and they are stored in the bladder before being excreted.

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Medical Specialties

Physicians are initially trained in general medicine and are awarded an MD (Doctor of Medicine) or DO (Doctor of Osteopathic Medicine) degree upon completion of four years of study. After completion of medical school, graduated physicians choose a specialty. This additional level of medical education is called a residency, which involves three to five additional years of training. After physicians complete their *residency*, some opt for additional training in their selected field. This further level of training is called a *subspecialty* and involves two to four more years of training.

As specialists, caregivers develop significant expertise in diagnosing and treating maladies in one of the body systems. Subspecialist physicians have even more expertise. For example, in the specialty of surgery, there are subspecialty neurosurgeons, orthopedic surgeons, hand surgeons, colorectal surgeons, ear, nose, and throat surgeons, and pediatric general surgeons, etc.

Medical care is also classified into levels. *Primary care* involves prevention and healthcare maintenance, screenings, acute illnesses, injuries, and coordination of care among specialties. *Secondary care* is referred to as the care rendered by a specialist. *Tertiary care* is the highest level of specialized care. Tertiary care is usually delivered within an academic hospital. *Quaternary care* is a higher extension of tertiary care and is usually associated with experimental medicines, procedures and treatments.

Medical care is also classified into levels: primary care, secondary care, tertiary care, and quaternary care.

Listed below is a partial array of medical professionals available to a patient residing in medium to large cities:

Family Practice – This is synonymous with primary care medicine. A family practitioner will diagnose and treat patients and families from infancy through geriatrics. Family Practice was once called General Practice.

Geriatrics – This is the study of wellness and illnesses unique to the geriatric population.

Obstetrics and Gynecology – Obstetricians and gynecologists study and treat illnesses associated with the female organs along with pregnancy and fertility.

Hematology – Hematologists study and treat diseases of the blood.

Internal Medicine – An internal medicine physician is dedicated to the treatment of adults. There are many subspecialties arising from the internal medicine model.

Emergency Medicine – These physicians are based in a hospital Emergency Department. Their training concentrates on stabilizing patients of all ages who have experienced severe illness or injury.

Neonatalogy – A neonatologist studies and cares for premature infants and newborn babies with serious illness.

Neurology – Neurologists study and treat nontraumatic disorders of the brain, spinal cord, and nervous system.

Oncology – Oncologists diagnose and treat cancers.

Otolaryngology – This branch of medicine is also known as ENT. These physicians offer medical and surgical care of patients with ear, nose, mouth, and throat maladies.

Pediatrics – Pediatricians study and treat wellness and medical illnesses of children and adolescents. There are many subspecialties.

Psychiatry – Psychiatrists study and treat mental disorders. Many subspecialties are found within this field.

Pathology – These physicians study what causes disease and monitor their effects, often through examination of tissues.

Pulmonology – This branch of medicine involves the study and treatment of respiratory system diseases.

Rheumatology – Rheumatologists are subspecialists within the internal medicine field that treat musculoskeletal disorders.

Surgery – Surgeons operate on the body to treat injuries and diseases. There are many areas of sub specialization.

Urology – A urologist is a surgical subspecialist focusing on the urinary system.

Common Medical Prefixes

Brachi – related to the arm

Cardio – related to heart

Cyto – related to cells

Derm – related to skin

Gastro – related to the stomach

Hemato – related to the blood

Histo – related to tissue

GI – related to the intestinal system

Myo – related to muscles

Neuro – related to the nervous system

Oculo – related to the eye

Oro – related to the mouth

Oto – related to the ear

Pulmo – related to the lungs

Common Medical Suffixes

algia – referring to pain (e.g., neuralgia)

emia – referring to conditions of the blood (e.g., anemia)

itis – indicates inflammation or infection (e.g., tonsillitis)

lysis – a breaking down (e.g., neurolysis)

pathy – relating to a disease (e.g., psychopathy)

pnea – relating to breathing (e.g., sleep apnea)

Medical Dictionary Descriptions Commonly Heard in the Clinic

Abrasion – a wearing away of the top layers caused by friction

Ambulatory – having the capacity to walk

Analgesia – loss of pain

Benign – not life-threatening, (e.g., a benign tumor)

Cavity – hollow space in the body

Compression – applying pressure

Etiology – the study of the causes of conditions

Idiopathic – of unknown causes

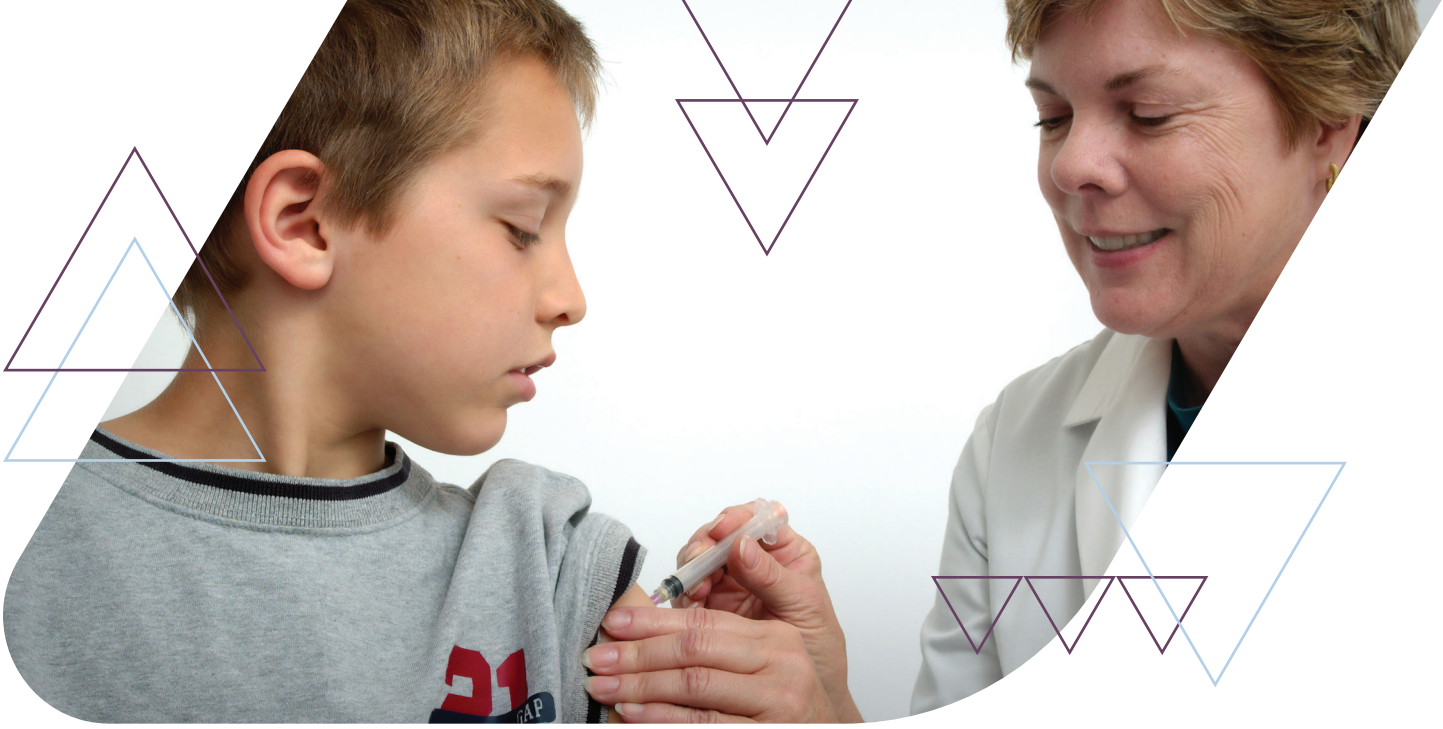
Reflux – going in opposite direction (e.g., acid reflux from the stomach into the esophagus)

Remission – reduction of previous signs of disease

Stimulus – something that elicits a physiological response

Subcutaneous – under the skin

Syndrome – a cluster of symptoms indicating a condition, disease or abnormality



Common Child-Adolescent Medical Conditions Presenting in Primary Care

Otitis media – a middle ear infection. It can be caused by bacteria or viruses. Ear pain and fever are common symptoms.

Respiratory Syncytial Virus (RSV) – a common pediatric respiratory illness that causes symptoms similar to a cold.

Colic – inconsolable, intense crying or fussiness in a baby who has no known health conditions. Colic typically doesn't last beyond the first few months of age.

Influenza – a seasonal viral infection, otherwise known as “the flu”. Symptoms include cough, fever, muscle aches, fatigue, runny nose, chills, and headaches. Yearly influenza vaccinations are recommended for people 6 months and older.

DPT vaccination – a vaccine to prevent diphtheria, tetanus, and pertussis.

MMR vaccination – a vaccine against measles, mumps, and rubella. The first dose is generally given to children between twelve to fifteen months of age, with a second dose at four to six years of age.

UTI – (urinary tract infection) a urinary system infection. Urinary tract infections are more common in women. They usually occur in the bladder.

MRSA – an aggressive form of the Staphylococcus aureus bacterium. MRSA commonly causes skin infections or boils. It is resistant to many of the commonly used antibiotics.

Asthma – a condition that causes wheezing and difficulty breathing. A person’s airways become inflamed, narrow, swollen, and produce extra mucus.

Rhinitis – a runny and congested nose that is typically the result of allergies or the common cold.

Sinusitis – a condition in which the cavities around the nasal passages become inflamed and infected. Can be triggered by a cold or allergies. Symptoms include headache, facial pain, runny nose, and nasal congestion.

Bronchitis – inflammation of the lung’s bronchial tubes. Symptoms include coughing, thickened mucus, and shortness of breath.

Strep – infections that can cause a variety of conditions, including strep throat. The infections are caused by Streptococcus bacteria and are typically treated by antibiotics.

Dermatitis – a skin inflammation that has a variety of causes and can take a variety of forms. Common symptoms of dermatitis are red, dry, and itchy skin.

Conjunctivitis – also known as “pink eye”; an irritation or inflammation of a part of the eye called the conjunctiva. It can be caused by allergies, a bacterial infection, or a viral infection. Conjunctivitis can be extremely contagious. Symptoms include watery eyes, redness, and itching.

Infant reflux – food returns from a baby’s stomach, causing the baby to spit up. Reflux of this type, also known as gastroesophageal reflux (GER) typically goes away with age.

Gastroenteritis – also known as the “stomach flu,” is a contagious infection marked by vomiting, diarrhea, and stomach pain.

Pneumonia – an infection that causes the lungs to fill up with fluid or infectious debris. Pneumonia causes trouble breathing, fever and a cough that may produce phlegm. The infection can be life-threatening to all ages, but is most worrisome in young children and older adults.

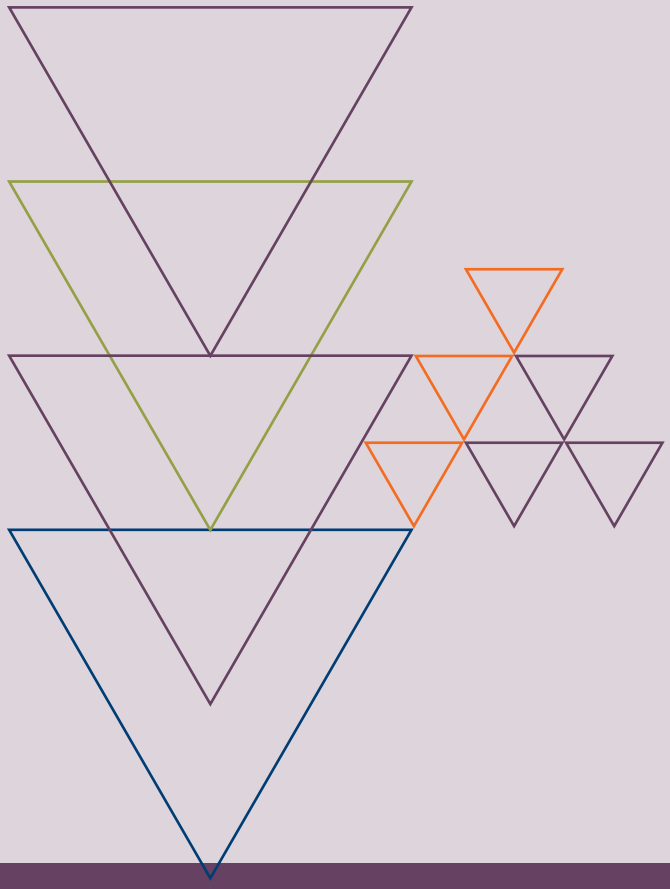
Constipation – infrequent bowel movements. Constipation can be due to many various causes, such as dehydration, lack of dietary fiber, inactivity, or medication side effects.

Lactose intolerance – a digestive disorder caused by the inability to digest lactose, the main dietary sugar in dairy products. Various symptoms include bloating, diarrhea, and abdominal cramping.

Allergy – an immune system response to substances, called allergens, seen by the body as a threat. Symptoms range from minor to life-threatening. Allergens can include foods, plants, animals, or medications.

Tips and Take-Home Points

- Behavioral health clinicians are typically not trained to practice in medical settings. Similarly, primary care physicians have very limited training in behavioral disorders.
- Integrated care involves teams of physicians, nurses, PAs, NPs, and behavioral health professionals (psychologists, social workers, psychiatric nurse practitioners, counselors and/or MFTs).
- Integrated care teams address behavioral disorders AND physical disorders that have behavioral sequelae and/or side effects.
- Having knowledge and understanding of medical terms enables BH clinicians to be efficient and contributing members to integrated care teams.
- Just as physicians refer to specialists in medicine for care involving specific disorders or highly involved healthcare needs, BH clinicians also need to develop specialty referral sources for patients with severe BH conditions or who are in need of long-term care.



Chapter 13

The Role of the Integrated BH Clinician in Primary Care Medication Management

As noted earlier in this manual, the first place that most parents take their children with behavior problems is to their primary care medical provider (Kessler and Stafford, 2008; Wildman et al., 2007).

Many primary care providers, however, are uncomfortable addressing behavioral or mental health concerns. Discomfort in behavioral health management comes from lack of training in behavioral health intervention, lack of time due to typical ten- to fifteen-minute visits, lack of behavioral health resources in the community for referrals, and limited capacity to provide follow-up services for patients requiring multiple sessions (Horwitz et al., 2007). At the same time, providers remain compelled to provide some type of intervention for their concerned families.

Primary care providers (PCPs) include physicians, nurse practitioners (NPs) and physician assistants (PAs). The PCP is dedicated to helping child, adolescent, and family patients with all types of healthcare problems. Consequently, when other behavioral health providers, such as a psychiatrist or a specialty-trained psychiatric mental health nurse practitioner are not available, the PCP will frequently provide interventions with psychotropic medications. For example, five pediatric clinics in a Midwest healthcare system without integrated behavioral health providers were assessed based on their prescriptive medication practices with young children. Although psychotropic medications are not recommended by the American Academy of Pediatrics for children under the age of six, 9 percent to 16 percent of children in these clinics, aged two to five, had been prescribed a psychotropic medication by their PCP.

Other data suggest that primary care physicians prescribe two-thirds of the country's anxiolytics (Mark et al., 2009) and over 50 percent of antidepressant medications (Antonuccio & Naylor, 2005). The number of children and adolescents diagnosed and treated for attention deficit hyperactivity disorder have risen from 6 percent to recent estimates of 10.2 percent over the past twenty years (Xu et al., 2018). This further confirms that PCPs are de facto mental health providers whether or not they feel comfortable or well-prepared for this role.

Data suggest that primary care physicians prescribe two-thirds of the country's anxiolytics. (Mark et al., 2009)

Integrated Behavioral Health Providers and Medication Management

The scope of practice for the prescription of psychotropic medications is limited to licensed physicians, NPs, PAs, and in a few states, specialty-trained psychologists. Other behavioral health professionals (psychologists, social workers, counselors, and marriage and family therapists) are not allowed by law to prescribe medications as this would be practicing within the scope of traditional medicine. Logically, there is a role for integrated behavioral health professionals related to medication management of behavior disorders. This role involves three functions:

1. Provision of information for accurate diagnosis
2. Providing behavioral health interventions as an alternative to, or concurrently with medication
3. Conducting follow-up assessment to help determine effectiveness of medications and any side effects that may be detrimental to the course of treatment

Diagnostic Assistance

Within pediatric practices, parents are often desperate for help with their children's behavioral issues and reach out to their trusted primary care providers for assistance. Some parents seek advice from their PCP about potential physical conditions that are causing behavioral difficulties at home or at school. Another parent group comes to the primary care medical clinic openly seeking a medication "cure" for their child's behavioral health problems. Having heard of positive results from friends, family members, or neighbors, a number of these parents are persistent and demand a diagnosis and psychotropic medication. Parents may even "doctor shop" until they find a PCP willing to prescribe. Still other parents are extremely opposed to psychiatric medications and already have had their children in therapy or counseling.

Primary care providers see the full spectrum of psychiatric disorders, from major depression to substance abuse to psychosis. They prescribe around 60 percent of psychotropic medications (Mark, Levit & Buck, 2009; Mojtabai, 2008.)

For all these families and children, an integrated behavioral health professional can assist in treatment by providing behavioral assessments confirming or discounting specific diagnoses. Behavioral health clinicians are trained to conduct accurate diagnostic evaluations, the results of which lead to the selection of appropriate treatments. For example, a course of psychotropic medication treatment based solely upon parent report or from results of a brief screening tool may not effectively address the presenting behavioral disorder. More in-depth assessment, testing, and diagnostic interviewing can lead to a more accurate differential diagnosis and recommendations for treatment. For example, during one six-month period in our ADHD clinic, we had an influx of ten referrals, all of whom were male, all eight years of age, all in second grade, and all being referred by teachers as having symptoms of ADHD-inattentive type. Further assessment indicated that none of these children could read at their grade level, and most were eligible for help through special education services. In two cases, we were able to recruit a relative to provide tutoring in reading. Upon follow-up, symptoms of inattention had disappeared. Without additional behavioral diagnostic assessment, consultation with the referring physician, and subsequent behavioral intervention, these children would have been labeled as ADHD, possibly placed on medication unnecessarily, and may have received services unnecessary or inappropriate for them to function optimally.

In summary, the provision of behavioral assessment to assist a PCP in diagnostic activities is an important role for the integrated behavioral health practitioner. Just as a PCP might use laboratory tests to confirm a diagnosis of streptococcal pharyngitis, behavioral assessment information can guide determination of a behavioral disorder and the course of appropriate treatment.

Provision of Behavioral Treatment Options

One of the major functions of the integrated behavioral health professional is to provide patients and the primary care team (physician, nurse practitioner, nursing staff, etc.) with behavioral treatment options based upon empirically supported practices. For the five Midwest primary care practices noted above, prescriptive rates for psychotropic medications for young children ranged from a low of 9 percent in one clinic to a high of 16 percent in another clinic. Overall averages indicated that 12 percent of two- to five-year-old's were being treated with psychotropic medications. Following the introduction of integrated behavioral health treatment into these practices, the rate of psychotropic use for young children in these clinics dropped to less than 2 percent over a four-year time span (Evans, Lancaster, Hosterman et al., 2017). Both patients and physicians expressed satisfaction with this approach.

It should be noted that psychotropic medications are appropriate and recommended in treating a number of behavioral health disorders. At the same time, and as recommended in practice guidelines by the American Academy of Pediatrics (AAP), behavioral interventions should be employed in conjunction with, or as an alternative to, medication management for most behavioral disorders of childhood and adolescence. For example, the 2019 AAP guidelines for the management of ADHD indicate:

- For preschool-aged children (age four years to the sixth birthday) with ADHD, the PCC should prescribe evidence-based Parent Training in Behavior Management (PTBM) and/or behavioral classroom interventions as the first line of treatment, if available.
- For elementary and middle school-aged children (age six years to the twelfth birthday) with ADHD, the PCC should prescribe FDA-approved medications for ADHD, along with PTBM and/or behavioral classroom intervention (preferably both PTBM and behavioral classroom interventions).
- For adolescents (age twelve years to the eighteenth birthday) with ADHD, the PCC should prescribe FDA-approved medications for ADHD with the adolescent's assent. The PCC is encouraged to prescribe evidence-based training interventions and/or behavioral interventions as treatment of ADHD, if available. Educational interventions and individualized instructional supports, including school environment, class placement, instructional placement, and behavioral supports, are a necessary part of any treatment plan and often include an IEP or a rehabilitation plan (504 plan).

Whether as a first-line intervention or as concurrent with medication management, behavioral treatment should be the treatment of choice for most child-adolescent disorders presenting in the pediatric primary care setting. The behavioral health provider should not only provide patients and families with behavioral treatment options but can also assist PCPs in making determinations about the appropriateness and timing for medication management. In at least one healthcare system, patients must first see a behavioral health professional for evaluation and possible treatment before referral to a psychiatric provider for medication management.

Medication Management Follow-Up

One of the concerns of PCPs providing behavioral healthcare is the lack of follow-up on interventions prescribed. Integrated behavioral health professionals can assist in this important function by monitoring effectiveness and side effects. Almost all psychotropic medications have potential side effects. Most of the side effects are harmless, but some can be problematic or debilitating. Use of a "side effect checklist" can help prescribers in determining if dosages are causing adverse effects. The side effects commonly reported with the use psychostimulants involve loss of appetite, difficulty sleeping, transitory headaches, and abdominal pain. There are stimulant side effects rating scales such as the Barkley Side Effects Questionnaire (BESQ) (Barkley, McMurray, Edelbrock, & Robbins 1990) that are helpful in monitoring side effects. Other side effect checklists developed for the treatment of depression include the Antidepressant Side-Effect Checklist (ASEC) (Uher, Farmer, Henigsberg, Rietschel, Mors, Maier, et al.,

2009). Side effect checklists should be completed by the child's parents prior to starting and during the period of treatment using psychotropic medications.

Additionally, psychotropic medications need to be monitored to ensure effectiveness and proper dosage. The behavioral health clinician can be helpful in gathering information from parents, teachers, or via direct observation of behavioral symptoms once the medications have been started. This information can then be compared with baseline (pre-medication) levels of severity to determine whether current prescriptions are having a positive effect on targeted symptoms or whether treatment strategies need to be reevaluated. For example, parents may report being satisfied that there has been an improvement in behavior in the school setting, but their child is still having significant difficulties at home in the evening. This suggests that medications should be reviewed for duration of effectiveness and home-based behavioral interventions should be added to the treatment plan. Conversely, some parents have reported concerns that their child is now behaving like a "zombie" after the introduction of or a change in medication levels. In this instance, there may be a question of appropriate dosage and consideration of alternative medications. In both cases, the behavioral health clinician can collect behavioral data, consult with the primary care provider/team, and offer suggestions for additional or alternative behavioral interventions.

Almost all psychotropic medications have potential side effects. Most of the side effects are harmless, but some can be problematic or debilitating.

Psychoeducation on Psychotropic Medications

Primary care provider knowledge and comfort in dealing with psychotropic medications vary greatly. We have encountered a small number of pediatric primary care providers who refuse to prescribe any type of psychotropic medication. They will typically refer the patient to a community mental health center or psychiatric practice. Other PCPs have a good working knowledge of psychiatric medications and use them judiciously. Most PCPs working with children and adolescents remain uncomfortable in prescribing other than basic psychostimulant, antianxiety and antidepressant medications. (Note: Some PCPs may ask the behavioral health professional for input on which medications to prescribe. Behavioral providers need to be cautious in recommending a specific medication rather than citing the class of medications used for a behavioral health condition due to scope of practice limitations.)

Although the majority of behavioral health providers (psychologists, social workers, marriage and family therapists, and counselors) are not licensed to prescribe medications, they need to develop basic knowledge of psychotropic medications to be contributing members of the primary care treatment team. Zuckerbrot et al., (2018) recommends routine monitoring of side effects as critical for depressed youth being treated with antidepressants. Patients from outside the primary care practice may come for therapy services having already been prescribed a number of psychotropic medications. Recognition of these medications and their side effects may require the patient's treatment team to consider reduction or elimination of certain medications or combinations of drugs. Be aware that some parents and patients have ill-conceived notions that taking certain medications is unsafe and will lead to addictions. Being able to provide, in coordination with the PCP, accurate information and reassurance about FDA-approved medications will often be helpful. It is always prudent to be alert for the interaction of physical symptoms or side effects when the goal of treatment is behavioral.

The remainder of this chapter focuses on classes and schedules of psychotropic medications along with some of the more commonly used medications for the treatment of attention deficit hyperactivity disorder, depression, and anxiety. This information is presented to expand the knowledge base of behavioral health clinicians as part of the integrated care treatment team.

Classes of Psychotropic Medications

Psychotropic medications are classified according to function. Medications are designed to treat specific groups of behavioral disorders, including depression, psychosis, anxiety, and ADHD. Below is a table describing the categories of psychotropic medications along with the names of some representative medications from each of the five classes (the PCBH Tool Kit, Mountainview Consulting Group, 2013). Notice that there are two names assigned to one medication. The first name in the list below is the generic name, and the second name in parenthesis is the trade name. Once a drug has been cleared for therapy, there is a period of time when it is sold under its patent, or trade, name. This version of the drug is usually more costly. After a period of time (usually around twenty years), the exclusive patent on the drug expires. The medication can then be manufactured and sold by other drug companies. The drugs are given a generic name and are then usually less costly. You often will hear the generic name and trade name used interchangeably.

Table 5. Categories and Names of Psychotropic Medications

CPT BILLING CODES	USE	EXAMPLES OF MEDICATIONS
Antidepressants Selective Serotonin Reuptake Inhibitors (SSRI) or Selective Norepinephrine Reuptake Inhibitors (SNRI)	Anxiety and depression	 fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro) Duloxetine (Cymbalta)
Mood stabilizers	Bipolar disorder	lamotrigine (Lamictal), valproic acid (Depakote), lithium carbonate (Eskalith)
Antipsychotics	Psychosis; irritability and aggression such as with autism spectrum disorders	risperidone (Risperdal), aripiprazole (Abilify), quetiapine (Seroquel),
Antianxiety agents	Immediate anxiety reduction	hydroxyzine (Vistaril), clonazepam (Klonopin), buspirone (Buspar)
Stimulants	ADHD	Methylphenidate (Ritalin, Concerta); mixed amphetamine-based salts (Vyvanse, Adderall).

Schedules of Psychoactive Medications

Psychotropic medications cannot be purchased over the counter and are not readily available without a prescription from a licensed medical professional. The Federal Drug Enforcement Agency (DEA) has designed a series of five schedules of controlled medications/substances based upon effectiveness and potential for abuse and addiction. The DEA determines on which schedule a medication is placed:

"Schedule 1 contains drugs that are deemed to have no medical utility and a very high potential for abuse; these generally cannot be prescribed. Schedule 5 contains drugs that are deemed to be helpful medically and have the least potential for abuse. Most of the opioids used for chronic pain are in Schedules 2 and 3. More anxious chronic pain patients may end up using some of the Schedule 4 medications."

Note that psychostimulant drugs have been placed into Schedule 2 along with opiates. The table below (from Robinson and Reiter, 2016) shows a sampling of the medications listed as controlled substances in each schedule:

Table 6. Controlled Substances

SCHEDULE	MEDICATIONS INCLUDED
Schedule 1	Heroin, marijuana/cannabis, peyote, LSD
Schedule 2	Cocaine, methadone, amphetamine (Adderall), methylphenidate (Concerta, Ritalin), oxycodone (OxyContin, Percocet), fentanyl (Duragesic)
Schedule 3	Vicodin, Tylenol with codeine, buprenorphine (Suboxone)
Schedule 4	Alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), clonazepam (Klonopin),
Schedule 5	Lyrica, Robitussin AC, other cough medications with a small amount of codeine

Medication Management—Psychostimulants

The most common behavioral medications prescribed in child-adolescent medical practices are stimulants, antidepressant drugs and antianxiety drugs. Stimulants are generally the medications of choice for treatment of ADHD. Immediate release stimulants (e.g., Ritalin, Adderall) have a short duration and take effect within twenty to thirty minutes. An advantage to the immediate release stimulants is that they have a short duration; therefore the potential for side effects is typically short-lived. Long-acting stimulants (e.g., Concerta, Vyvanse) generally take approximately thirty to sixty minutes to show effectiveness. The duration varies, but most remain effective for approximately six to ten hours. The following table lists the stimulant and non-stimulant drugs that are typically prescribed to treat ADHD symptoms. This list is not meant to be comprehensive, and new psychostimulant medications are regularly introduced to the market approximately every two to three years. It is important for integrated behavioral health clinicians to keep up with new medications through attending product introduction presentations, reviewing some of the research published on the drugs, and making notes of reported side effects.

Table 7. Stimulant and Non-Stimulant Drugs Commonly Prescribed for ADHD

SCHEDULE	MEDICATIONS INCLUDED
Long-acting stimulants	mixed amphetamine salts (Adderall XR) mixed amphetamine salts (Mydayis) methylphenidate (Concerta) methylphenidate (Daytrana) dexmethylphenidate (Focalin XR) methylphenidate (Jornay PM) methylphenidate (Ritalin LA) lisdexamfetamine (Vyvanse)
Short-acting stimulants	dextro-amphetamine (Dexedrine and Dexedrine Spansules) dexmethylphenidate (Focalin) methylphenidate (Ritalin, Methylin)
Non-stimulants	atomoxetine (Strattera) guanfacine (Intuniv XR)

Medication Management—Anxiety and Depression

The evidence-based medications used in the treatment of anxiety and depression are the selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs). These medications usually take two to four weeks before becoming fully effective and are thought to have a positive influence on mood, emotion, and sleep. For further information on understanding the mechanisms of psychotropic medications for anxiety, depression, and ADHD, see the online training module on Psychotropic Medications. Behavioral interventions for anxiety are well-researched and include cognitive behavior therapy, exposure, diaphragmatic breathing, and relaxation training. These techniques are discussed in detail in the online module on Anxiety. Some research has found behavioral interventions to be as successful as, and more enduring than, medications. Combinations of medications to treat anxiety and behavioral interventions have been found to be more effective than either treatment alone (Hollon et al., 2006). Behavioral interventions for youth with depression are also effective and include cognitive behavioral therapy, interpersonal therapy, and behavioral activation strategies (Weisz & Kazdin, 2017).

Anxiety disorders include (Bhatt, 2019):

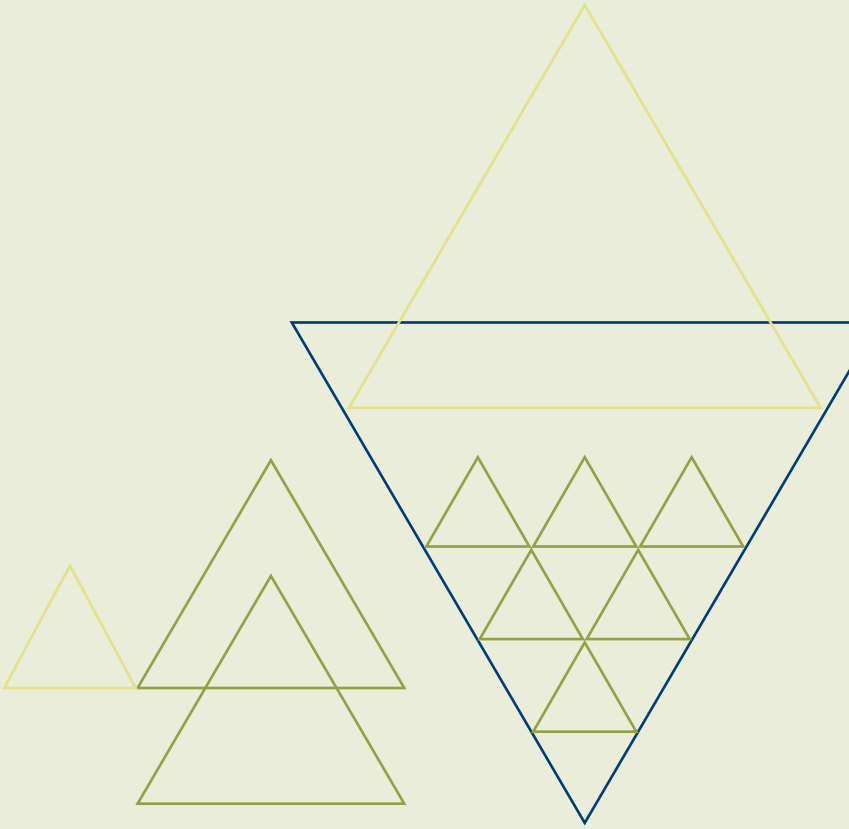
- separation anxiety disorder
- selective mutism
- specific phobia
- social anxiety disorder (social phobia)
- panic disorder
- agoraphobia
- generalized anxiety disorder
- substance/medication-induced anxiety disorder
- anxiety disorder due to another medical condition

The following SSRIs and SNRIs are commonly prescribed medications for anxiety and depression in children and teens. These may include medications such as:

- Prozac (fluoxetine)
- Celexa (citalopram)
- Zoloft (sertraline)
- Lexapro (escitalopram)
- Cymbalta (duloxetine)

Tips and Take-Home Points

- Primary Care Physicians, PAs, and NPs have become “de facto” mental health providers largely due to lack of available behavioral health services, inadequate insurance coverage, and timely scheduling for their parents.
- While the American Academy of Pediatrics recommends behavioral treatment for most childhood BH disorders, there remains a controversy as to which comes first, behavioral intervention or medication.
- Although Primary Care Providers often indicate some discomfort and inadequate training in dealing with mental health problems, PCPs prescribe approximately 60 percent of all psychotropic medications.
- The integrated BH clinician has three roles in medication management in primary care: diagnostic assistance, provision of behavioral options for treatment, and follow-up assessment of medication for effectiveness and side effects.
- BH clinicians are not medication prescribers but need to be aware of appropriate prescription usages, dosages, and behaviors impacted by various psychotropic medications.
- BH clinicians should be aware of classes and schedules of psychotropic medications. Information on specific drugs is available on the BHMeds-R3 app.



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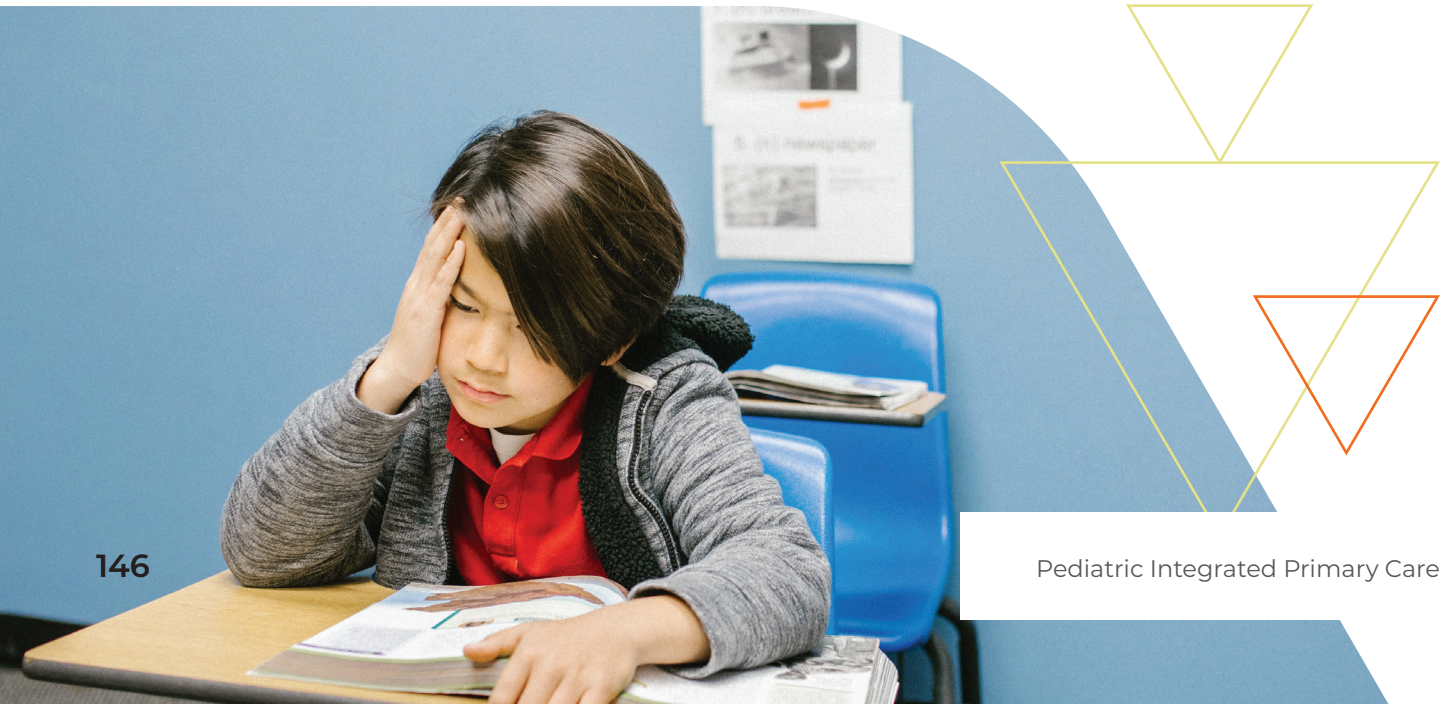

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