Primary Care/Behavioral Health Integration Efforts in North Carolina

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Building upon the foundation work begun by the ICARE Partnership in 2006, the North Carolina Center of Excellence for Integrated Care, Community Care of North Carolina, and the North Carolina Division of Medical Assistance have been working together to advance and expand integrated care.

North Carolina is viewed as a leader in the field of integrated primary and behavioral health care. Through the efforts of an array of public and private funders and service delivery partners, models have been developed that demonstrate the culture and process changes necessary to improve patient outcomes and reduce barriers to service delivery. These innovative approaches support the goals of the 1915(b)/(c) Medicaid waiver [1], piloted in North Carolina in 2005 and recently approved by the General Assembly for statewide expansion by 2013. The goal of the expansion is to establish “a system that is capable of managing public resources that may become available for mental health, intellectual and developmental disabilities and substance abuse services” [2]. Consumers of these services need improved access to high-quality behavioral health care and primary care in order to better manage all types of chronic conditions.

Integrated care is a biopsychosocial approach to care planning and service delivery that greatly enhances the transition to a patient-centered medical home or similar structure of care. The evolution of bi-directional care affords a patient an opportunity to receive screening, brief intervention, and appropriate referral to more intense levels of treatment by offering behavioral health services in medical settings and physical health screening in specialty behavioral health provider organizations. Simply increasing collaboration between primary care practices and behavioral health provider agencies has been an important first step in assuring coordinated care. Service delivery models may range from co-location with a specialist offering direct or consultative services to selected patients onsite, to a fully integrated medical and behavioral health team approach where every patient has access to a full array of multidisciplinary providers.

The North Carolina Division of Medical Assistance (DMA), the North Carolina Center of Excellence for Integrated Care (the Center), and Community Care of North Carolina (CCNC) have worked collaboratively to support the advancement of integrated care across the state. By bringing together policy and funding (the DMA), training and consultation (the Center), and applied practice (CCNC), the alliance has achieved significant progress. This is an overview of their cooperative accomplishments during the past 5 years and their vision for the future of integrated care in North Carolina.

The Center of Excellence for Integrated Care

The Center is a program of the North Carolina Foundation for Advanced Health Programs (NCFAHP); it is dedicated to improving patient health and wellness by fostering integrated care for both physical and behavioral concerns. This integration is achieved by ensuring that health care providers collaborate to provide patient-centered care. Working with multiple partners and stakeholders, the Center ensures that consistent, evidence-based standards of care are adopted across health care settings, so that patients receive care that employs best practices wherever they seek treatment.

The Center grew out of the work of the ICARE partnership, an initiative that, between 2006 and 2009, helped North Carolina become a national leader in integrated care. Three-year funding for ICARE was provided by the Duke Endowment, the Kate B. Reynolds Charitable Trust (KBR), AstraZeneca, North Carolina’s Area Health Education Centers (AHEC), the North Carolina Department of Health and Human Services, and NCFAHP. In 2010, Governor Beverly Perdue endorsed ICARE, saying that it had set the stage for what we should be doing in health care today. That year, funding was made available to the Center through the North Carolina Health and Wellness Trust Fund, the DMA, and the Office of Rural Health (through a Children’s Health Insurance Program Reauthorization Act [CHIPRA] federal grant). Current funding comes from continuance of the CHIPRA grant, new grant funds from KBR, and contracts with the Governor’s Institute for Substance Abuse and other agencies of the North Carolina Department of Health and Human Services.

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Integrative Care: What the Research Shows

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Because the majority of patients with mental illness are treated by generalist physicians, primary care has been described as the “de facto” mental health system [1]. Unfortunately, outcomes for patients with common mental illnesses treated in primary care settings are often poor. Fewer than half of patients with depression recover within 6 months of starting treatment, and outcomes are worse for minority and low-income patients [2, 3]. Studies show multiple problems with the quality of care, including underdiagnosis, inadequate dosage and duration of treatment when psychotropic medication is prescribed, and infrequent follow-up [4, 5]. Early attempts to improve patient outcomes focused on improving care for depression through clinician education and depression screening, but these efforts largely failed. However, important lessons were learned, and it was hypothesized that outcomes could be improved by integrating mental health care with primary care and delivering that integrated care in a primary care setting.

Over the past 2 decades, integrated care has been evaluated in a series of randomized controlled trials (the strongest design for testing a new treatment intervention). In the initial studies, including a 1995 study by Wayne Katon and colleagues [2], adult patients with depression were cared for jointly by a mental health professional and a primary care physician at the same location; often the patients alternated visits with the two providers. These studies showed improved outcomes with this approach; however, it was thought to be too expensive and to strain an already limited supply of mental health professionals. The model evolved into a team approach that incorporates specially trained nurses, pharmacists, or health coaches and makes greater use of telephone follow-up to increase the frequency of contact at reasonable cost. These integrated approaches also borrow from Edward Wagner’s chronic care model [6], empowering and preparing patients to manage their own health and health care. More systematic follow-up, stepped-care treatment algorithms, disease registries and decision support have been introduced. Decision support often takes the form of having a mental health professional supervise the nurse, pharmacist, or health coach. Various permutations of this integrated care model for depression have now been evaluated in more than 40 trials, some of which have included up to 2 years of follow-up.

High-quality systematic reviews [7, 8] have shown that, compared with primary care treatment alone, integrated care for depression doubles the rate of medication adherence and significantly improves symptoms of depression, functional status, and patient satisfaction. In one large trial involving 1,801 older adults, treatment lasting 1 year was shown to have positive effects that were still present at 2-year follow-up, including decreased pain scores in the subset of depressed patients who also had arthritis [9-11]. The results for patients from ethnic minority groups and those with low incomes were as good as or better than those for the group as a whole.

More recent trials have shown that these positive effects extend to depressed patients who have a concurrent condition, such as a chronic medical illness (diabetes mellitus or coronary artery disease, for instance), generalized anxiety disorder, or panic disorder. Integrated care that focuses on mental health outcomes does not have a halo effect that improves general medical outcomes [12]. However, when integrated care uses similar methods for both depression and chronic medical conditions, increasing follow-up and measurement-based care for both, outcomes for both (including measures of disease control such as glycated hemoglobin and serum cholesterol levels) are improved [13, 14]. Integrated, collaborative care of this sort has been shown to be highly cost-effective, and in some subgroups of patients, it has actually produced cost savings [15, 16].

What are the key ingredients of integrated care? An analysis that sought to identify the components of integrated care that have been consistently associated with greater impact on symptoms of depression [17] concluded that the most important features are active care by the primary care physician, collaboration with a mental health professional, adherence monitoring, treatment response assessment using a symptom scale, active support for patient self-management skills, and integrated treatment lasting at least 16 weeks.

How can integrated care for depression be promoted in North Carolina? The state’s primary care physicians support integrated care, and the approach described here is consistent with the “medical home” team-based medical care delivery model. However, given current systems. The Center is a resource for government, hospitals, health systems, the health care industry, Local Management Entities (LMEs), CCNC networks, health care payers, and the public. It serves as a “think tank” in which these stakeholders develop best-practice models that meet the needs of primary care and behavioral health patients and providers in a collaborative, strength-based approach to service delivery. (A strength-based approach builds upon the per-
son’s strengths, rather than focusing on their weaknesses or problems.) The Center’s staff members provide onsite and telephonic technical assistance and training. Coaching for practice change and for model sustainability through continuous quality improvement is customized for practice sites and enhanced by the growing use of electronic health records.

Through demonstration projects, models of bidirectional care are being developed to provide appropriate behavioral health services in primary care settings and medical interventions in behavioral health settings. The emphasis is on disease management and early identification of medical and behavioral health issues, with brief intervention and referral to appropriate specialty treatment.
The Center’s Web site (www.icarenc.org) is a comprehensive and accessible state-of-the-art information delivery system. The site has had more than 1,139,000 page views and more than 430,000 visitors, and there have been nearly 200,000 downloads of resource materials. The Center regularly updates and expands the substantial resources for health care providers that are available on the site. Those resources include evidence-based tools and techniques, clinical protocols, third-party reimbursement training, information on research in integrated care, training and technical assistance to eliminate barriers to integrating care, implementation guidance, community resources (by county), and models for increased patient access to care.

Community Care of North Carolina

To begin implementing the Center’s models for integrated care, CCNC began a Behavioral Health Integration (BHI) program in 2010. The BHI initiative supported the hiring of 19 psychiatrists to work in the 14 CCNC Networks across the state. In addition to these part-time psychiatrists, 14 full-time behavioral health coordinators were hired to support each network’s efforts to integrate primary care and behavioral health care. This coordinated behavioral health team was charged with providing support to local care managers, providing education about models of behavioral care to health care practices, and establishing liaisons between the primary care provider community and the behavioral health community, which have long existed as separate silos of care.

The goal of the BHI program has been to break down the primary care and behavioral health care silos by linking the two types of practice. The initial phase of the program focused on identifying the behavioral health resources available to primary care providers in their local communities and providing a liaison between the two. A critical component was to reintroduce to one another the two provider groups, who were serving the same population of patients but had a limited relationship. With the support of the Center, models of co-location have been proposed that range from simple consultation to actual physical location of behavioral health resources in a primary care practice. Adoption of any of these co-location models enhances the ability of health professionals to serve patients in a more effective and efficient manner.

Another focus of the BHI program has been to increase the use of best-practice models of care. With the integration of behavioral health care with primary care, the opportunity to provide prevention and early identification of many health problems has become a reality. Prior to this integration, the behavioral health community focused largely on providing crisis services with the limited resources available. In the current integrated model, the ability to screen for substance use disorders using the SBIRT approach, to identify depression early using a brief patient health questionnaire (the PHQ-2 or the PHQ-9), and to diagnose attention-deficit hyperactivity disorder in children using the Vanderbilt Assessment Scale makes it possible to intervene early in these conditions by beginning treatment in the primary care setting. The BHI initiative provides guidelines and education to help primary care physicians treat these conditions successfully, and it helps identify community resources when it is time to refer patients to psychiatric specialty services.

The BHI initiative introduced motivational interviewing to the care managers of CCNC as a tool to engage and empower patients to assume responsibility for their own care. Motivational interviewing is a best practice that has been shown to impart to patients a sense of empowerment, with the result that they participate actively in their care, become more autonomous in caring for themselves, and adhere better to regimes for chronic disease management (such as smoking cessation, diet, and medication). This type of interviewing is a skill that is learned with much practice and the support of colleagues. CCNC offers its 600 care managers extensive training through webinars, a day-long classroom training, and monthly follow-up that includes coaching and providing technical assistance in a small group setting for 12 months. This training has been provided state-wide through North Carolina’s AHEC system. Motivational interviewing supplements limited resources in the primary care and behavioral health fields by deploying an untapped resource for care: the patients themselves.

The North Carolina Division of Medical Assistance

Since the 1980s, the DMA has been developing policy to support the use of patient-centered medical homes through multiple managed care initiatives. In 1991, the Centers for Medicare and Medicaid Services (CMS) approved a section 1915(b) Medicaid waiver that allowed mandatory enrollment of select Medicaid eligibility groups into “primary care case management” programs. The first such program was Carolina Access, and then CCNC was added during an expansion in 1998. Both programs allowed open access to primary care and preventive services, and both required primary care physicians to provide and manage specialty medical services for Medicaid enrollees in their practices. These physicians were, in turn, enrolled in CCNC networks, which provided disease management for the entire Medicaid population in a local coverage area. However, early Medicaid policy did not address the fact that a significant amount of mental health treatment was being provided by primary care physicians. In 2009, the DMA updated the CCNC contracts to include additional capitation funding for initiatives aimed at treatment and management of behavioral health conditions at the primary care physician level as well as at the network level.

In the early 2000s, the Medicaid behavioral health benefit began to expand in accordance with mental health reform in North Carolina by creating policy for specialty community-based services delivered by a private provider network. The DMA contracted with LMEs to provide care management to high-cost, high-risk recipients with behavioral health needs and to provide behavioral health care referrals for any
Medicaid enrollee. North Carolina began implementation of a 1915(b)/(c) Medicaid waivers program with a pilot project in 2005 and, in 2009 and 2011, expanded the waivers statewide, with the intent of having a greater number of existing LMEs become DMA vendors for oversight of the specialty behavioral health care system by 2013.

Other DMA policies at the recipient and provider level have evolved to support integrated care efforts. DMA recipient initiatives in recent years have aimed at enrolling additional eligibility groups in the CCNC networks, most notably those eligible to receive Aid to the Aged, Blind, and Disabled—an enrollee group with a high use of specialty behavioral health services and supports. In 2009, DMA began reimbursing colocated mental health therapists for assessments, smoking cessation counseling, and substance abuse screenings using the SBIRT approach. All new clinical policy updates for specialty behavioral health services require coordination with, and in some cases referrals from, the patient’s CCNC primary care physician. Through collaborative efforts with the Center, the Office of Rural Health, and CCNC, the DMA developed a “Mental Health/Substance Abuse/Developmental Disability Integrated Care Toolkit” for behavioral health providers. This toolkit offers guidance on coordinating care with the recipient’s CCNC physician and explains how to access the recipient’s CCNC medical information.

DMA is finding it challenging to keep the momentum of integrated care efforts going, as specialty behavioral health care continues to be carved out and managed by the LMEs apart from the CCNC networks. Some physician practices express concern over the need to enroll their embedded behavioral health staff in an LME network and bill psychotherapy codes to the LME. Part of the answer may lie in the flexible payment structures allowed under a 1915(b) waiver and under the Affordable Care Act. LMEs can incentivize the use of co-located behavioral health professionals by using differential (or higher) rate structures based on episode-of-care or avoidance of higher-levels of care when treatment is provided in the primary care setting. LMEs can offer an expanded unmanaged outpatient therapy benefit when care is provided in a CCNC practice. LMEs are also required (per the DMA contract) to collaborate with the local CCNC networks on care coordination of recipients with serious and persistent mental illness. It is imperative for individual physicians and CCNC networks to see that the LMEs are resources for recipients with complex behavioral health needs who need treatment beyond brief, strategic behavioral health interventions. The success of the health home (medical home) model and the effectiveness of overall holistic health care of the Medicaid recipient hinges on the collaborative efforts of CCNC and the LMEs. To that end, DMA will continue joint workgroup efforts with the North Carolina Center of Excellence for Integrated Care, CCNC and LMEs.

Advancing Integrated Care

North Carolina is well positioned to continue to be a leader in the field of integrated care. Building on the significant work accomplished through the collaboration of the DMA, the Center, CCNC, and additional public and private stakeholders, we can leverage the principles of health care reform into the future. Adoption of high-quality, performance-based approaches to prevention, early intervention, and chronic disease management is a critical component of innovative models of care. As provider practices become certified as patient-centered medical homes, they must establish models of collaborative, team-based care. Meaningful use of health data will offer opportunities for examination of the impact of integrated practice across health care settings. New models of funding to support an effective care management system are emerging through pilot programs supported by public and private payers. The Center plans to continue to convene a wide array of stakeholders to serve as the think tank for advancing the vision of integrated care in North Carolina.

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References
