BRIEF REPORT

INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE: A REVIEW OF EVIDENCE AND RECOMMENDATIONS FOR OSTEOPATHIC FAMILY PRACTICE

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ABSTRACT

Osteopathic family physicians embody the philosophy of whole-person care, including using a biopsychosocial approach to incorporate mental health into patient care. The creation of the Behavioral Health Integration Collaborative increased support for a system-level adoption of whole-person care in primary care settings. With the increase in both mental health symptoms and diagnoses among Americans, and the increasing support for integrated physical and behavioral healthcare in the primary care setting, this paper shares various approaches, as well as challenges to, adapting integrated care in the primary care office. This includes reviewing best practices for implementing this care approach. The two leading models for integrated care are the Primary Care Behavioral Health (PCBH) model and Collaborative Care model (CoCM). Both models include clinically embedding licensed mental health professionals into the primary care setting, thus increasing access to colleagues with this specialized approach. The PCBH model utilizes a warm hand-off approach, resulting in a collaboration between physician and mental health provider in the care of the patient. The CoCM focuses on a registry of patients who are overseen by a behavioral health manager with treatment decisions guided by a consulting psychiatrist. Blended models are also emerging to better suit the needs for different practices and the patient populations they serve. Challenges to full implementation include acquiring buy-in from practice leadership, hiring appropriately trained mental health providers, and defining billing and coding procedures.

INTRODUCTION

As osteopathic family physicians, holistic care is at the heart of our practice. Across diverse practice settings and patient populations, we treat the whole person using the tenets of osteopathic medicine grounded in a biopsychosocial approach.[1] Integration of mental health into medical treatment plans, which has contributed to the success of primary care and family medicine for decades,[2] is integral to our practice philosophy. A foundational sentiment of our profession says, "To find health should be the object of the doctor; anyone can find disease.[3]" Whole-person care rests at the intersection of physical, mental, emotional, and spiritual aspects of life.[1-3]

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Recent national conversation about whole-person care has amplified these philosophical concepts. In the wake of the COVID-19 pandemic, the Behavioral Health Integration Collaborative was formed, bringing together eight national physician organizations (including the American Osteopathic Association and the American Academy of Family Physicians) to advance the system-level adoption of whole-person care in the primary care setting.[4,5]

For osteopathic family physicians in practice, it is critical to understand how these system changes are different from how we inherently practice as osteopathic physicians. This paper aims to describe the landscape of mental health access, highlighting the pressures specific to primary care, to educate the osteopathic family physician on the leading and emerging evidence driving behavioral health integration system change, and to offer best practices and common pitfalls for implementing behavioral health within osteopathic family medicine practices

THE CURRENT LANDSCAPE OF MENTAL HEALTH ACCESS

One in five American adults experience some form of mental illness, and less than half of those with an identified concern receive treatment.[6] Wait time, cost, access, and stigma serve as significant barriers to timely, holistic care.[6] Groups with multiple marginalized identities are at significant risk; for example, Black transgender and nonbinary youth report disproportionate rates of suicide risk, with 59% seriously considering suicide and one in four attempting suicide in the past year.[7] The COVID-19 pandemic has exacerbated these problems. Prevalence of depression and anxiety was higher during the pandemic compared to earlier years, especially among individuals under age 60 years, racially and ethnically minoritized groups, and those with educational levels less than a four-year college degree.[7,8]

Given these realities, primary care is now the "de facto" frontline of mental health care.[6] Upwards of 70% of primary care concerns have a mental health component, and family physicians prescribe a significant portion of psychotropic medications.[6] Integrated care is uniquely positioned to bridge the gaps between demand for mental health services and access to appropriate treatment.[6] Mental health care is often unaffordable without insurance; those with private insurance may face limitations that inhibit access, as specialized mental health providers may be "out of network" or do not accept insurance, thus driving more individuals back to primary care.[9]

The National Behavioral Health Integration Collaborative aims to provide sustainable practices for physicians and behavioral health providers to successfully work together.[5] This collaborative encourages implementation of models that recognize each clinician's unique contributions and conceptualization of all presenting concerns in the context of the patient's social identities, lived experiences, and social determinants of health.[5] For successful integration, the two specialties must work together to create a culture of inclusivity and a commitment to social justice, while also addressing health care disparities and maintaining mutual respect and appreciation for their roles.

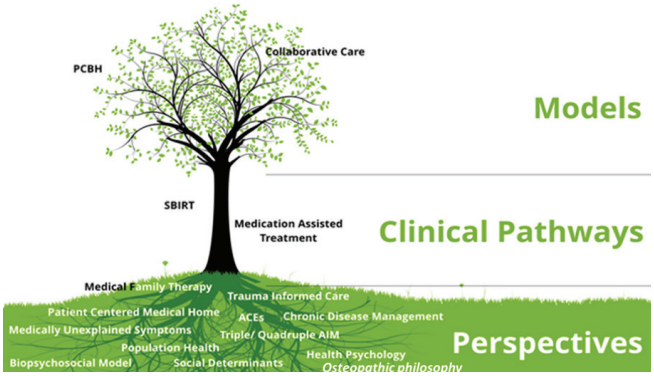
INTEGRATED CARE

Background and Basics

Integrated care is defined as "the care a patient experiences as a result of a team of primary care and behavioral health clinicians working together with patients and families using a systematic, cost-effective, and evidence-based approach to provide patient-centered and holistic care to a population."[9] This concept can be implemented using a variety of pathways and models (Figure 1).[10] The osteopathic philosophy shares similar themes of holding the patient at the center of care while seeing the patient as a whole person.

FIGURE 1:

The integrated care tree of models and clinical pathways rooted in perspectives Adapted from the Collaborative Family Healthcare Association, 2023[10]



Integrated care is delivered along a spectrum, ranging from coordinated, referral-based models, to co-located with basic collaboration principles, to fully integrated care (Table 1).[11] In coordinated care, each specialty works in parallel to the other, and while clinicians might consult each other and collaborate on care plans, they remain systematically separated, with the patient having to traverse between them.[11] In co-located care, clinicians are physically seeing patients in the same office and may work with the same patient for similar concerns. However, each provider maintains separate treatment plans, electronic health records, and other distinct workflows that limit cohesion in care and communication.[11] In fully integrated care, all clinicians work together, often consulting with each other at the time of care delivery, working from shared plans, workflows, and structures that create a unified holistic experience for the patient.[11]

TABLE 1:

Levels of integrated care, from coordinated, to co-located to integrated care

COORDINATED CARE		CO-LOCATED CARE		INTEGRATED CARE	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed Practice
Level 1: Separate facilities, separate systems; clinicians rarely communicate about cases.	Level 2: Separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone, letters and notes.	Level 3: Separate systems, shared facilities. Proximity supports occasional face-to-face meetings and regular communication.	Level 4: Some common systems in common. Regular face-to-face interactions among PCPs and BHCs, coordinated treatment plans for difficult patients. Basic understanding of each other's roles and cultures.	Level 5: Mental health and others share the same sites, vision and systems. All providers are on the same team, have developed an in-depth understanding of each other's roles and areas of expertise.	Level 6: Full collaboration into one system, team and patients view the operation as a single health system treating the whole person, for all patients.

Adapted from Substance Abuse and Mental Health Services Administration, 2023.[11]

Two Leading Models: Primary Care Behavioral Health and Collaborative Care

Two key models for integrated behavioral health have been studied in the literature (Table 2).[12] The Primary Care Behavioral Health (PCBH) model is characterized by having behavioral health clinicians or consultants (BHCs) working together with primary care providers (PCPs) utilizing warm hand-offs as a key component to collaboration.[12] A warm hand-off occurs when a PCP actively

introduces a BHC to a patient during a primary care office visit to jump-start engagement with the BHC for services.[13] BHCs provide support for the full spectrum of mental and behavioral health concerns, using a functional and contextual perspective to identify and prioritize the patient's goals.[14] BHC services are brief, problem-focused, and behaviorally oriented. For patients with concerns that cannot be safely or effectively addressed in primary care, the BHC works to help the patient successfully engage into the specialty mental health environment.[12] Collaboration with a behavioral health team member at key moments in care allows the PCP to move forward with the schedule, reducing clinician frustration from running late while ensuring that challenging cases are shared by a clinician with the appropriate training and expertise.[14,15] Further, patients are given immediate and affordable access to care.

The Collaborative Care Model (CoCM) is characterized by the creation of a registry, overseen by a behavioral health manager (BHCM).[14] Patients are identified through evidence-based screening, such as the PHQ-9 or GAD-7,17 and enrolled into a registry.[13-16] Treatment decisions are maintained under the purview of the PCP with guidance from a consulting psychiatrist (CP).[14] The CP meets regularly with the BHCM to review cases, and together, the BHCM and CP use an algorithm-based stepped-care model informed by evidence-based assessments for treatment decisions.[17] Patients tend to meet with their care manager for brief remote check-ins that can be offered over the phone, with episodes of care typically lasting from 3 to 12 months.[13]

TABLE 2:

Key features of two leading models of integrated care

Primary Care Behavioral Health Model	Collaborative Care Model
Integrated **behavioral health consultant available for *warm hand-offs***	Integrated **care manager overseeing registry** of patients with mental health diagnoses
Evidence-based previsit screening for mental health conditions (ie, PHQ2/9, GAD2/7, AUDIT-C) by PCP to help identify care needs	Evidence-based screening and diagnosis by PCP to help identify care needs; measurement used regularly by PCP/behavioral care managers to systematically track treatment
Evidence-based behavioral treatments delivered within primary care setting	Algorithm-based stepped care using evidence-based tools to guide treatment, with decision support for complex mental health cases by **consulting psychiatrist (CP)**
Treatment duration: typically <6 sessions	Treatment duration: 3 to 12 months
>30 randomized controlled trials demonstrating effectiveness	>90 randomized controlled trials demonstrating effectiveness

Adapted from American Psychological Association, 2021.[14]

Blended models are also emerging, which combine aspects of both PCBH and CoCM within primary care settings.[12] In these settings, PCPs and BHCs work closely on shared teams, using warm hand-offs to episodically assist patients through behavioral management with mild-moderate mental health concerns, and engaging patients with depression and anxiety into the CoCM arm of care.[12] Blended models have the potential to offer "the best of both worlds," in that patients and PCPs appreciate the immediate access provided through the in-office BHC, while also benefitting from the high-level psychiatric consultation in the CoCM model.[12] Consulting psychiatry can also be protocol-driven treatment and is automatically utilized for severe or intense cases.[12]

Core Team Members

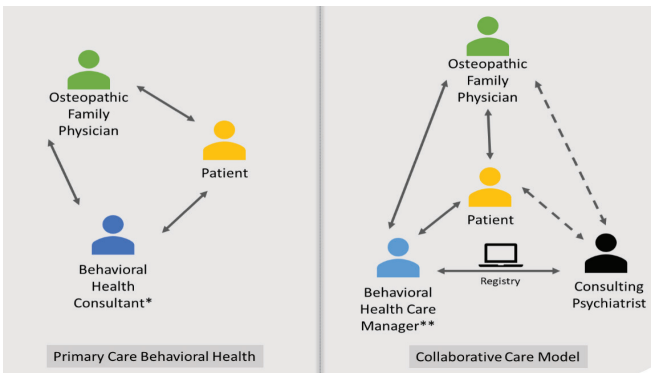
Integrated care models (both PCBH and CoCM) depend on a multidisciplinary team of professionals who are clinically embedded into the primary care setting; the teams in each of these models are slightly different (Figure 2).[13]

In PCBH, BHCs are licensed mental health clinicians who are trained to work closely with PCPs to empower patient self-management of health concerns.[12] BHCs differ from traditional therapists because they are brought in by the PCP to deliver brief problem-focused services.[12] The goal is to address issues before concerns escalate to require more complex specialized mental health care. BHCs work with patients on specific behavioral issues, such as medication adherence, smoking cessation, insomnia, and sleep hygiene; they can also be engaged for anxiety, depression, trauma, bereavement, relationship issues, and substance use concerns.

Alternatively, in CoCM, BHCMs are the novel team members.[13] BHCMs can be psychologists, social workers, registered nurses, or similarly-trained individuals; their primary role is to oversee the registry of primary care patients with mental health diagnoses while leveraging algorithmic stepped-care tools to engage patients with guidance from a CP.[14] In this model, the CP infrequently communicates with the clinical team, instead engaging through the BHCM to manage the registry.[14]

FIGURE 2:

Multidisciplinary team members in the two key models of integrated care. Adapted with permission from AIMS Center.[13]



*Behavioral Health Consultant refers to an embedded mental health professional in a primary care setting who provides interventions for medical conditions that have a behavioral health component and does this for the entire population of the clinic.
** Behavioral Health Care Manager refers to an embedded mental health professional in a primary care setting who provides treatment to patients with behavioral health diagnoses.

Solid line indicates frequent communication; dashed line indicates infrequent communication.

IMPLEMENTION INTO OSTEOPATHIC FAMILY PRACTICE

Getting started with implementing integrated behavioral health into a primary care practice depends on executing a few crucial factors successfully (Table 3).[20,21] This process begins with making the business case for hiring appropriately trained staff, including start-up resources to support change management. The three major areas of potential initial investment are hiring behavioral health professionals, engaging with a CP, and delineating billing and coding procedures.[4,13]

Hiring and Training Behavioral Health Professionals

Whether implementing PCBH or CoCM, behavioral health professionals are essential members of an integrated behavioral health team and will need to be hired into a family practice. While BHC postdoctoral-level training programs exist in the United States, the distribution of appropriately trained behavioral health consultants is variable by geographic location.[19] Therefore, it is incumbent upon the practice leaders to be attuned to this variance during the hiring process to ensure the appropriate understanding of integrated care and a proficiency in behavioral health practice. Variances in training, background, and context explain some of

TABLE 3:

Best practices for behavioral health integration into osteopathic family practice

Leadership Mission and Vision for Integrated Care	Organizational leaders need to frame importance of integration and provide resources and funding support to embed properly trained mental health professionals within the primary care setting
Shared Goals and Philosophies	Osteopathic philosophy aligns strongly with integrated care principles; an osteopathic physician can establish clear goals for the practice to support whole-person care
Clear Roles and Expectations	CPs and BHCs benefit from clarity in the details related to professional titles, location in clinic, and accountabilities in clinical expertise. This improves efficiency, reduces redundancy, and allows the entire team to take advantage of the division of labor, thereby accomplishing more than the sum of its parts
Mutual Trust and Communication	Team members earn each other's trust over time, by establishing and refining multiple lines of communication; this creates strong norms of reciprocity and greater opportunities for shared achievement
Designing Protocols and Workflows	Efficiency is also created when clear workflows are delineated for how patients will access BHC services and how patients will be routed through the clinical spaces for their care. Defining previsit and in-visit screening frequency and methods (ie, PHQ/GAD), initiation of warm hand-offs, orchestration of offices for each team member to use, and visit closure and follow-up planning are all crucial to outline during implementation.
Measurable Processes and Outcomes	Team members develop metrics together; this implements reliable and timely reporting using iterative approaches to improving care in real-time, improving systems in addition to enhancing care.
Demonstrating Value and Financial Stability	Efficiency is also created when clear workflows are delineated for how patients will access BHC services and how patients will be Behavioral health integration requires start-up funding to hire appropriately trained BHCs, but practices can soon break even or create revenue if coding and billing procedures are utilized to capture productivity of visits and warm hand-offs

Adapted from American Psychological Association, 2021.[13]

the differences in work culture between primary care and mental health settings.[15] Osteopathic family physicians should also be aware that the busy fast-paced environment of a typical primary care practice can seem quite different than typical mental health settings, where schedules are typically fixed, reasons for seeking care are defined at the outset, and data privacy and confidentiality are paramount.[14,21] For example, in primary care, patients present with a wide range of health issues that are triaged accordingly throughout episodes of care and may be referred on to specialty services as needed. Specialty mental health environments, on the other hand, tend to have a focused scope and clearer set of patient expectations at the outset. These differences may initially be less comfortable for a mental health professional not accustomed to the same level of flexible boundaries, shifting roles, and continuity of relationships over time and across many family members and generations.[15] Having this insight, as well as searching for potential hires who have thrived working in fast-paced medical environments, are essential to facilitate a smooth onboarding process and success in the position.[21]

Engaging with Consulting Psychiatry

Finding consistent psychiatric referral resources can be challenging, putting many osteopathic family physicians in the position of managing or stabilizing psychiatric conditions within the primary care setting. Leading researcher and CP, Lori Raney, MD, has observed, "The shortage of a sufficient psychiatric workforce to address these needs, coupled with forces such as stigma that deter engagement in treatment, has led to the call for psychiatrists to work with other professions to develop new delivery models to provide effective care to the greatest number of people possible."[21] Thus, despite variance by demographic region, the development of the role of CP has also been emerging within health systems and communities across the country.[23]

A CP is defined as a licensed, credentialed, and specialty-trained psychiatrist serving as a leader, educator, and champion of the CoCM model.[21] Psychiatrists working in these roles provide direct and indirect consultation to PCPs and BHCs within a defined primary care population, which may be organized by patient panel or care setting.[21] This role is a required member of the clinical team for practices utilizing the CoCM model for both care and billing. Indirect consultation, also known as "curbside consultation," is the most frequent type of consultation utilized in this model. Here, support is given by the psychiatrist to the PCP via discussing patient care plans without the psychiatrist directly evaluating patients; the expectation is the PCP will implement the recommendations at their discretion.[21] Direct consultation, or face-to-face evaluation by the psychiatrist, is reserved for patients who do not respond to indirect consultation or for whom the primary care team requests assistance with diagnostic clarification.[21] In this case, care responsibility remains with the PCP, however, the CP does not order additional workup and provides recommendations only for the PCP to utilize at their discretion.[21]

Osteopathic family physicians may already be working with psychiatrists in their communities, hospital systems, or organizations. This is an efficient opportunity to partner with an existing colleague who likely is already a good fit in culture, workflow, and philosophy when initiating integrated behavioral health. Contracting for partial time availability for consultation can be done to appropriately bill for services. Of note: recent coding guidelines do not require the CP to provide care on-site, as long as appropriate documentation is completed in the primary care electronic health record.[4,9]

Defining Billing and Coding Procedures

Over the past few years, Current Procedural Terminology (CPT) codes have been added to create value for integrated behavioral health services.[4] While not an exhaustive list, there are several codes that a practice can use as a starting point (Table 4).[4] Codes can be used to account for time spent in visit-based care (common in the PCBH model), as well as total time spent per month on integrated behavioral health services (common in the CoCM model).

TABLE 4:

Relevant CPT codes to be used in integrated behavioral health in primary care[4]

Counseling Risk Factor Reduction and Behavior Change Intervention	*Preventive Medicine* • 99401, 99402, 99403, 99404 (Individual) • 99411, 99412 (Group) *Behavior Change Interventions* • 99406-99407 Smoking and tobacco use cessation counseling visit • 99408-99409 Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention (SBI) services
Psychotherapy	• 90832, 90834, 90837 Psychotherapy (30, 45, 60 min) • 90833, 90836, 90838 Psychotherapy when performed with E/M service • 90853 Group psychotherapy
Health Behavior Assessment and Intervention	• 96156-96171 (Individual, Group, Family) Focus on psychological, behavioral, emotional, cognitive, and interpersonal factors, and factors complicating medical conditions and treatments
Care Management	• 99484 General behavioral health integration care management

CONCLUSION

National support for behavioral health integration creates an important opportunity for osteopathic family physicians to model the philosophy of practice, which has grounded our profession throughout its history. In addition to the success factors at the practice level, institutional leadership support is crucial to fund the start-up costs associated with hiring, training, and implementing change management for these models.[5] Though transformation in health care can be challenging, the benefit is a strengthened clinical team who together can deliver outstanding clinical care, commit to the mental health of its population, create return on investment, and invigorate joy in work, thereby modeling and thriving within the Quadruple Aim for patients, staff, and the community.

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