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Position paper

Improving Integration of Behavioral Health Into Primary Care for Adolescents and Young Adults

Society for Adolescent Health and Medicine

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A B S T R A C T

Problems related to mood, substance use, anxiety, body image issues, post-traumatic stress, and suicidality are common in adolescence and become even more common in young adulthood. Integrated behavioral health (IBH) in primary care has shown great promise in identifying and treating adolescents and young adults who have these problems. Treatment outcomes in IBH settings outperform those in usual primary care settings where a primary care provider may identify behavioral health problems and refer youth to colocated or outside behavioral health specialists. Despite the success of IBH care systems, limited training opportunities and inadequate financial compensation for these services jeopardize the wide scale expansion and universal adoption of IBH. To optimize patient care, providers from all disciplines in adolescent primary care settings should have dedicated professional training in IBH. This should include incorporating IBH professional competencies into each discipline's formal training program and building interprofessional, multidisciplinary IBH training settings. Likewise, payers should work with primary care systems to create and implement reimbursement models for IBH services. Efforts to expand the footprint of IBH would pay off significantly by building more worldwide BH systems with increased efficacy at identifying and treating adolescents with BH conditions.

Positions of the Society for Adolescent Health and Medicine

Position #1: Professional medical and behavioral health training programs should identify and implement integrated behavioral health training competencies to meet the current and future behavioral health needs of adolescents and young adults in primary care settings.

Position #2: Medical and behavioral health training programs should include robust exposure to integrated behavioral health settings to build a behavioral health–competent primary care workforce.

Position #3: Payers should implement financial and administrative policies to encourage expansion and sustainability of integrated behavioral health systems in primary care.

Statement of the Problem

Behavioral health (BH) is a broad term that describes the interrelationship between individuals' behaviors, mental, and physical health as related to their functioning. BH includes disorders of mood, substance use, anxiety, body image issues, post-traumatic stress, and suicidality. BH disorders are common with estimated lifetime risks between 18% and 55% worldwide and prevalence rising linearly from early adolescence into adulthood [1]. Nearly half of all lifetime BH disorders begin by the mid-teen years and 75% by the mid-20s [2]. Many BH disorders are associated with impaired functioning in nearly all domains—educational, economic, health, social/relational—and missed opportunities during a key time in development. Severe outcomes such as suicide are rising in the United States (US); with rates increasing annually among adolescents and young adults by 10% and 5.6%, respectively [3]. Untreated BH problems are common throughout much of the world [4], particularly in low- and middle-income counties (LMIC) where the treatment gap is up to 90% for youth [5]. Poor identification and treatment compromise adolescents' immediate and long-term health and elevates their risks for early morbidity and mortality, including suicide. Evidence-based treatments for BH problems are available, but adolescents inconsistently access them. Over the past two decades, the medical and BH professional communities explored solutions to bridge this gap. Integrated behavioral health (IBH) is an effective model for identifying and treating BH conditions in both adolescents and adults [6]. It can destigmatize BH conditions

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and treatments for patients and health-care professionals it also can prevent and interrupt dysfunction associated with adverse childhood events, life stressors, chronic medical illnesses, somatic symptom disorders, and health care overutilization.

IBH is defined as both BH and medical providers functioning together as members of the primary care team. It can serve as a BH management model in most primary care settings including academic, private practice, large health systems, school-based health centers, and safety-net clinics. IBH providers comanage patients through shared screening systems, treatment planning, and medical record systems, providing much stronger integration than usual care (facilitating referrals) or provider colocation [7]. Importantly, a variety of professionals (physicians, physician assistants, nurse practitioners, nurses, care coordinators, licensed social workers, psychologists, and psychiatrists) and trained community members can serve in this model.

IBH, as a model, is particularly important for LMIC. Only a third of LMIC have a national BH policy and most LMICs have a low budgetary allocation of less than 1% for BH [8]. The number of psychiatrists in LMIC is 72 times lower than high-income countries [9]. Hence, shifting BH care to community members operating in primary care settings is vital for timely and appropriate treatment.

Several countries have recognized the importance of expanding IBH to reduce the BH access crisis [10]. Leveraging this model of care to improve BH outcomes on a large scale will require dedicated attention to preparing future primary care and BH workforces through training and career opportunities within primary care practice settings (academic, community, and private practice).

The Society of Adolescent Health and Medicine serves as the largest interdisciplinary professional body focused entirely on the well-being of adolescents and young adults. Many professionals in adolescent health have unique exposure to multidisciplinary BH training environments and IBH. The Society of Adolescent Health and Medicine provides a unique platform to highlight progress in expanding IBH and identifying key next steps to create an IBH-competent workforce. The goals of this position paper are to (1) encourage medical and BH training directors and institutions to implement IBH training competencies; (2) expand exposure to IBH multidisciplinary training environments in medical and BH training programs; and (3) implement payment and administrative policies to ensure sustainability for IBH in both the training and practice settings.

Methods

This statement is based on an extensive literature search from the medical, psychological, social work, and nursing fields regarding IBH training and financing opportunities, and includes US and international expert review.

Positions and Recommendations

Position #1: Professional medical and behavioral health training programs should identify and implement integrated behavioral health training competencies to meet the current and future behavioral health needs of adolescents and young adults in primary care settings

Professional competencies provide the basic structure to guide formal training for a variety of health-related disciplines [11]. Medical and BH educators use professional competencies to establish uniform expectations so trainees may acquire a broad array of clinical and professional skills.

Training in BH management is often underemphasized compared to other health-care competencies. Despite concerted efforts to create BH training competencies for primary care health-care providers [11], many medical training programs lack emphasis on BH skills [12]. Consequently, medical trainees report a lack of preparation to manage BH problems.

Additionally, health-care providers do not receive adequate IBH-specific skill development during training to successfully perform in IBH settings. As recently as 2013, a minority of social workers (SWs) in IBH settings in the US felt prepared to practice in their roles right out of training [13]. SWs in IBH settings report they learned most IBH skills on the job. Even then, SW demonstrate incomplete knowledge concerning crucial IBH principles and practices [13] including evidence-based practice which may result in inadequate translation of the demonstrated beneficial clinical effects of IBH [6].

Professional IBH competencies have been developed by several disciplines. The field of psychology led the development of IBH professional competencies by recognizing the need for psychologists in primary care to have specific IBH skills and to evaluate and address gaps in these skills [14]. SWs have since taken up the mantle and created specific IBH training competencies for SWs in primary care settings [13]. Investigators have developed specific IBH competency tools for SWs in training and in the field [15]. Most recently, the medical field has identified the importance of IBH skills for primary care providers. Specifically, psychiatry and family medicine have IBH competencies for trainees [16,17]; however, gaps remain in pediatrics and internal medicine [11].

While individual disciplines have explored their responsibilities to prepare trainees for IBH, national and international organizations/resource centers have created core multidisciplinary competencies for all professions in IBH. BH professionals have sought to emphasize common IBH competencies needed among the psychology, social work, and psychiatry disciplines [18]. In 2014, the Substance Abuse and Mental Health Services Administration, published core competencies for medical and BH professionals, which is intended to shape workforce training and guide professional competency sets [19]. The World Health Organization (WHO) and others have outlined interprofessional skills, mindsets, and clinical structures needed to develop and support IBH on both the provider and practice levels [20].

BH training is underemphasized in general, and with the creation of the Milestone Project in US medical training, specific training competencies (BH included) have taken a back seat to broader, more general competency bands. To prepare our future workforce to meet adolescents' and young adults' BH needs, the competencies created through the above efforts should be adapted, implemented, and championed by the larger medical and BH educational communities.

Each national program should work with medical education regulatory bodies, national registration authorities, and ministries/departments of health to create and implement competencies to include broad international and country-specific standards. Each country has different health service structures and ways of implementing IBH. Thus, context-specific competencies are vital [20].

Position #2: Medical and behavioral health training programs should include robust exposure to integrated behavioral health settings to build a behavioral health–competent primary care workforce

IBH training in the psychology and social work disciplines is necessary to prepare BH specialists to effectively integrate into primary care settings. This includes exposure to team-based care, warm handoffs, curbside consultation, stepped-care, and case management. Many trainees lack significant exposure to these principles. Robust training in actual IBH settings is needed to prepare SWs and psychologists in their roles as IBH providers and care managers [13].

Likewise, exposing all primary care–focused medical residents to IBH in their training clinic settings would likely positively impact the overall BH management competency of the future workforce. IBH training environments provide extensive interaction between primary care and BH providers. These settings lead to multiple opportunities for trainees to develop specific IBH and general BH management competencies [21].

Practicing clinicians report significantly richer BH training experiences when trained in primary care clinics with IBH versus those trained in usual primary care [22]. These experiences lead to increased confidence in managing and collaborating on BH issues in their current practice setting(s) [22]. Comanagement alongside IBH providers during training is specifically associated with increased confidence in managing multiple BH problems. Trainees in clinics with IBH are more likely to assess for BH problems and refer to treatment than those trained in usual care [23]. They also report greater awareness of internal BH resources [23]. Medical trainees consistently rate direct collaboration with BH providers as highly important for their learning [24].

Family practice has led in incorporating IBH training into professional training experiences. Other medical specialties that include adolescent populations (i.e. pediatrics and internal medicine) should strive to match these rich training environments [25]. Current programs have varying degrees of integration, which differentially impacts professional educational experiences [26]. The projected expansion of IBH provides the opportunity to further shape IBH programs for specific subgroups of adolescents and young adults and to investigate optimal training structures across different primary care settings [5].

Ultimately, training in IBH is likely optimized through co-occurring multidisciplinary training models. Using these models, dually located medical and psychology trainees mutually build skills in IBH as they prepare for their careers in primary care [27]. Other promising models include primary care trainees, BH providers, and psychiatrists training together in a medical residency training clinic [28]. Even more inclusive training models might also prepare BH specialists or nurse team members to function as BH care managers. Exposure to these models provides trainees with opportunities to observe IBH in action, interact with mentors modelling IBH practices, and practice BH and IBH skills themselves. In settings where these models are scarce, academic institutions might take the lead in integrating training opportunities for multiple disciplines. This allows students to consider the adaptation of these models into their future practice settings in either governmental or nongovernmental patient service settings. This also allows for advocacy toward the development of an IBH model in countries just beginning to build their BH infrastructure.

Several examples of in-person and online continuing education opportunities are available. The AIMS program at the University of Washington, the Behavioral Health and Integration Training Institute at Radford University, the Certificate Program in Integrated Primary Care at Fairleigh Dickinson University, the KySS Program at Ohio State University, the Web-Based Certificate for IBH and Primary Care through the University of Michigan, and the MHPOD in Australia are a few examples. Both the Substance Abuse and Mental Health Services Administration (www.thenationalcouncil.org/integrated-health-coe) and the American Academy of Child and Adolescent Psychiatry (www.integratedcareforkids.org) maintain Web sites highlighting IBH training, funding, and implementation tools. Federal funding for multidisciplinary training in adolescent and young adult health, such as that provided by the Maternal and Child Health Bureau to the Leadership Education in Adolescent Health in the United States, can provide opportunities for rich interdisciplinary BH training. However, these training opportunities could be significantly expanded and incorporated into fundamental primary care physician, nursing, psychology, social work, and psychiatry training experiences.

The WHO has led the charge for effective mental health care in LMICs. The WHO Mental Health Gap Action Programme (mhGAP) has designed training modules for child and adolescent developmental and behavioral disorders. This evidence-based algorithmic approach improves diagnosis and management of mental, neurological, and substance use disorders for community members in a primary care setting using a task-shifting approach. The mhGAP has been adopted by more than 100 countries. A recent systematic analysis found mhGAP guides improved mental health-care services in LMICs [29].

In summary, in order to develop a BH competent primary care workforce, significant energy must be invested to develop robust training opportunities for all care disciplines crucial to IBH.

Position #3: Payers should implement financial and administrative policies to encourage expansion and sustainability of integrated behavioral health systems in primary care

Numerous financial and administrative barriers impede the provision of IBH in primary care [30,31]. Current challenges may include problems with a patient's benefit coverage; lack of payer recognition of specific current procedural terminology (CPT) codes; issues with BH provider scope, licensure, or supervision; contracts not allowing primary care/BH providers to receive payment for certain types of services; or back-end denials due to documentation problems. Each barrier likely has a different path to achieve resolution, and each involves careful analysis of the integrated BH care services and staffing provided in primary care in relation to each individual payer's contract/policies.

In response to persistent and widespread criticisms over inadequate payment for IBH services in primary care in the US, several new fee-for-service billing and value-based payment (VBP) options have been introduced over the last several years. CPT codes now cover a broad set of assessments, brief BH interventions, diagnostic evaluation and psychological testing, psychotherapy, medication management, consultation, and care management services. Certain CPT codes, such as psychiatric collaborative care services (CPT 99492, 99493, and 99494), effective in 2018, allow for care management support over a month service period for primary care patients receiving BH treatment and ongoing psychiatric consultation to the primary care team [32]. To guide the use of new and existing codes, the SAMSHA-HRSA Center for Integrated Health Solutions, in 2014, published a set of state-specific integrated care billing and

financial worksheets that can be adapted for primary care sites using current CPT codes and rules [33]. Countries with private pay mechanisms can consider advocating for similar fee structures to enhance access to behavioral health services.

A growing number of commercial payers and health systems are introducing VBP initiatives using different payment methodologies to reward quality and cost-effective care [34]. Linked to specific delivery system goals (e.g., reductions in inpatient and emergency department admissions, antidepressant medication management, improved access) or clinical/organizational changes (e.g., provision of integrated BH and primary care plan or tracking outcomes related to social determinants), these VBP methods can include infrastructure investments, per member per month payments, pay for performance, bundled payments, and shared savings. To ensure readiness for VBP contracts, understanding patient utilization patterns, risk stratification, and costs are key issues along with having care coordination capacity and access to data to measure selected quality metrics.

In resource-limited settings, as mental health systems expand, policy and community leaders have a unique opportunity to build programs that include payment structures to account for the personnel needed for a truly integrated system [35].

Many expanded payment opportunities and publicly available resources to guide effective billing for IBH in primary care are now available. It is incumbent upon clinical and administrative leadership in the medical and BH settings to leverage them to advance IBH in training and practice settings.

Summary

Research consistently demonstrates superior patient outcomes in primary care settings with IBH. Importantly, IBH improves access to BH care in a cost-effective manner throughout high- and low-resource US and international communities [20,36]. As such, there is a great need for improved BH training within IBH primary care settings.

Across disciplines, formal professional training in medical and BH care should include IBH skills and experiences. Primary care clinical and administrative leaders are encouraged to look for ways to expand IBH and ensure its sustainability [7]. Policymakers and leaders should follow the evidence and build or improve on current financing structures to expand and reinforce IBH in primary care whenever possible.

Prepared by:

Brian Pitts, M.D.
Division of Adolescent Medicine
University of Colorado School of Medicine
Aurora, Colorado

Matthew C. Aalsma, Ph.D.
Division of Adolescent Medicine
Adolescent Behavioral Health Research Program
Indiana University School of Medicine
Indianapolis, Indiana

Merrian Brooks, D.O., M.S.
Children's Hospital of Philadelphia
Craig Dalsimer Division of Adolescent Medicine
Instructor Department of Pediatrics University of Pennsylvania
Faculty Botswana UPenn Partnership
Gaborone, Botswana

Preeti Galagali, M.D., P.G.D.A.P.
Bengaluru Adolescent Care and Counselling Centre
A unit of Radha Ortho & Pediatric Centre
Bengaluru, Karnataka, India

Robert McKinney Jr., Ph.D., L.I.C.S.W.
Department of Psychiatry & Behavioral Health and
Department of Family, Internal, & Rural Medicine
College of Community Health Sciences
The University of Alabama
Tuscaloosa, Alabama

Peggy McManus, M.H.S.
The National Alliance to Advance Adolescent Health
Washington, DC

Melissa Pinto, Ph.D., R.N.
Sue and Bill Gross School of Nursing
University of California, Irvine
Irvine, California

Ana Radovic, M.D., M.Sc.
Division of Adolescent and Young Adult Medicine
University of Pittsburgh School of Medicine
UPMC Children's Hospital of Pittsburgh
Pittsburgh, Pennsylvania

Laura Richardson, M.D., M.P.H.
Division of Adolescent Medicine
Department of Pediatrics
University of Washington/Seattle Children's Hospital
Seattle, Washington

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