

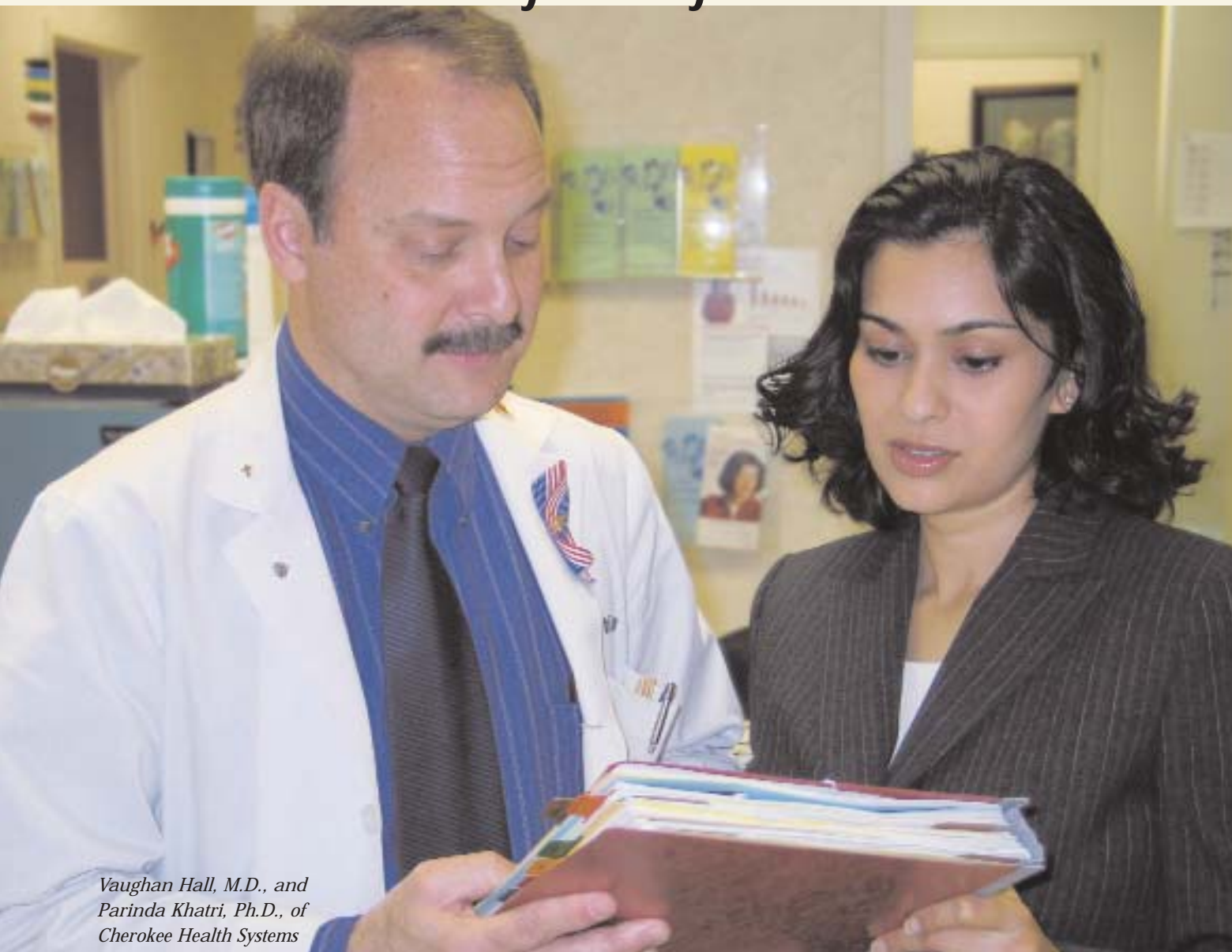
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# Behavioral Healthcare Tomorrow

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## Can Primary Care Docs and Behavioral Specialists Work Together? They Already Are



*Vaughan Hall, M.D., and  
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# The Road to Integrated Care: Commitment Is the Key

*Tennessee CMHC demonstrates promise  
of co-located behavioral and primary care*

By William Kanapaux

Integrated care has been a hot topic ever since large staff-model health maintenance organizations (HMOs) such as Kaiser Permanente-Northern California and Group Health Cooperative of Puget Sound first began co-locating behavioral health specialists in their primary care clinics.

But for many community mental health centers (CMHCs) burdened by tight resources and a high demand for services, the trend toward integration has appeared to hold more peril than promise.

“The major impetus in my experience for integrating behavioral health is almost always coming from the primary care side of the system,” said Kirk Strosahl, Ph.D., a psychologist and consultant specializing in integrated care. Community mental health centers “seem almost oblivious to the fact that the majority of mental healthcare is being delivered not in the [community mental health] clinic, but in the community health clinic.”

Many CMHCs have reacted in a self-destructive way by viewing integrated-care efforts by community health centers as a threat to their turf, Strosahl said. “I doubt that this short-sighted approach is going to help much. The future of American healthcare is going to involve integrated primary care.”

But one CMHC in Tennessee, a state that is no stranger to funding problems in its mental health system, has proven itself to be a model for how this kind of integration can work in the public sector.

Cherokee Health Systems may be unique as a CMHC that over the years has expanded into a complete community health system, but CMHCs in other parts of the country can learn from its experience.

Dennis S. Freeman, Ph.D., chief executive of Cherokee Health Systems, got first-hand experience in inte-

grated care in the late 1960s as a community mental health outreach worker. He saw patients within the primary care setting and worked alongside primary care doctors.

“There are more mental health problems in the primary care sector than in the mental health sector,” said Freeman. And primary care doctors are aware of this.

In 1978, Freeman came to Cherokee, in east Tennessee, and continued the “circuit riding” model with area community health centers, he said. He opened the first integrated site there in 1984 by co-locating a primary care provider and a psychologist.

Cherokee, which has annual revenues of about \$30 million, now has 18 service locations, and all but three have primary and behavioral healthcare co-located. Psychiatrists are present in most of the settings in a consulting role, while psychologists actively see patients on a regular basis.

The system employs 24 psychologists, 12 psychiatrists and 25 primary care providers. It also has about 10 pre-doctoral psychology students who work part-time. The system covers a 14-county region that’s largely rural and lacking in resources.

Despite the problems faced by the state’s TennCare program, which serves Medicaid-eligible and uninsured residents, Cherokee continues to grow, Freeman said. Unlike other CMHCs in the state, Cherokee has contracts not only with the behavioral health organization that manages TennCare’s behavioral health carve-out, TennCare Partners, but also with TennCare’s general managed care organizations.

Cherokee sees about 40,000 unduplicated patients over the course of a year. “There’s no way that we could manage that number of folks if we didn’t have the interplay between primary care and mental health,” Freeman said.



*Vaughan Hall, M.D., and Parinda Khatri, Ph.D., of Cherokee Health Systems*

Having a behaviorist on the primary care team increases efficiency for primary care providers, who don't get bogged down trying to do hour-long sessions with distraught patients.

Probably two-thirds of the 40,000 patients have had at least some visit with the behaviorist over a two-year span, Freeman said, and that doesn't count "curbside consultations" between providers.

For a long time, primary care doctors have tried to make referrals to specialty mental health services, but that has proven difficult given the demands placed on mental health systems and the lack of patient interest, he said. "If they can get somebody in, more often than not they can't get the patient to go, so they just continue to treat the patient."

So it's logical to inject a behaviorist into the primary care setting to do interventions as part of that treatment team, Freeman said.

"We are meeting an unmet need," said Parinda Khatri, Ph.D., Cherokee's director of integrated care. People with behavioral health problems are not getting optimal treatment. "Because they're not going to go into specialty care, we're meeting them where they are."

The goal of the program is to improve screening and identification of mental health problems in primary care settings and to improve the quality of treatment while facilitating communication among providers, Khatri said. "The patient comes to us as a whole person, so we're trying to treat them as a whole person."

### **Different cultures, same patients**

Behavioral health carve-outs pose a difficult barrier to

integrating care, and mental health systems vary widely from state to state. Often, Freeman said, CMHCs are relegated to treating priority populations, while primary care centers are open to nearly everyone.

The cultures are different, but the patients aren't, he said. About half of the patients who enter the Cherokee system do so through behavioral health, while the other half enter on the primary care side. Using standardized instruments for measuring emotional distress and depression, Cherokee staff have found no difference between the two populations.

When Freeman started doing outreach in the 1960s, the similarities became immediately apparent, he said.

"The intakes I was seeing in the community mental health center were exactly like the presentations I was receiving at the community health center," he said. A person can go into any primary care practice, particular if it serves low-income people, and find a significant number of patients with chronic psychiatric problems who are being managed within primary care.

Freeman continues to do clinical work one day a week in an integrated setting and had recently consulted with a primary care doctor about a patient who was hallucinating, psychotic and suicidal. Primary care doctors at community health centers treat patients like that every day, he said.

Many of these patients feel that primary care is their healthcare home, and if they are sent out on referral to a specialty mental health provider, "Many of them just don't go," Khatri said. But if a behavioral health specialist is on site for brief assessments and discussions about adhering to a treatment plan, "That automatically increases [patients'] comfort level in

addressing these issues.”

The patient sees the behavioral health specialist as part of the healthcare team, and the trust that the patient has in the doctor is extended to the consultant, Khatri said. “That usually doesn’t happen when the behavioral health provider is in a different office.”

### **What about the money?**

Reimbursement, however, remains a challenge, Freeman said.

Primary care providers immediately understand that it makes sense clinically to integrate care, and patients see it as an advantage, but established reimbursement streams are an obstacle, Freeman said.

“You can bill under primary care for primary care services, you can bill under mental health for mental health services, but when you try to integrate the service and you put a behaviorist on a primary care team, it’s tough to get paid,” he said.

In 2002, Medicare began paying for updated Current Procedural Terminology (CPT) codes for psychological services that help treat or manage physical health problems. The codes, 96150-96155, cover assessment, reassessment and intervention at the individual, group and family levels.

Other payers, however, are generally unaware of the new codes, Freeman said, and it will require a lot of education to get them to establish payment methodologies and enter the codes into their systems.

Expanding the 96150 series of codes would represent a major step in the right direction, he said. Currently, the codes are restricted to patients who do not have a psychiatric diagnosis. To Freeman, that makes little sense.

“I’ve never talked to a primary care provider who didn’t tell me half their work is mental health,” he said. “Primary care providers are seeing patients all the time with psychiatric diagnoses, often with other diagnoses too.”

If a behaviorist provides an intervention service within a primary care setting, that service should be paid regardless of the diagnosis because the service is the same whether the patient has diabetes and is not adherent or has depression and is not adherent, Freeman said.

Getting reimbursed for integrated care can be tricky, and most services are billed separately, Khatri said. As a nonprofit organization committed to the underserved, Cherokee is not looking to make a lot of money but it doesn’t want to lose money either. The message from Freeman, she said, is to “do what seems clinically right and we’ll find a way of working things out.”

Khatri says that she hopes more payers take up the codes. In the meantime, the health system has to eat some of the costs, especially consultations with primary care doctors on how to manage a patient’s care. A Community Access Program (CAP) grant from the federal Bureau of Primary Care pays for the place-

ment of behavioral health providers in Cherokee’s primary care clinics, and a grant from the federal Maternal and Child Health Bureau allows for integrated-care services in its pediatric clinics.

Primary care providers also have trouble getting paid for an office visit if the presenting issue is psychiatric, even though existing codes cover those visits, Freeman said. Primary care doctors are generally paid based on the level of complexity for an office visit, on the number of organ systems investigated. But payers often reject claims for psychiatric diagnoses if they are submitted by a primary care provider.

Because of this, a patient’s record will list symptoms, such as tension headaches or sleep problems, rather than the diagnosis. “If you see depression, and you know you’re treating depression, why not diagnose it, rather than just listing the symptoms?” Freeman said.

Stronger leadership on these issues from the Centers for Medicare & Medicaid Services (CMS) would be helpful “because a lot of payers follow that lead,” he said. Medicaid administrators know by the drugs prescribed, if nothing else, that a great deal of mental healthcare is being delivered by primary care providers.

Cherokee has brought up the issue with TennCare’s medical director, and he agreed that it made good sense to use the codes, Freeman said.

### **Staffing issues**

Workforce issues are also a problem, Freeman said. “There are not a lot of clinicians that are trained to do this.”

Cherokee has a pre-doctoral internship program, and virtually all of the graduate students in the psychology department at the University of Tennessee spend time in it.

“The challenge is finding really good people to do this,” said Khatri, who directs the internship program. The skills required to be a behavioral health consultant are different from those traditionally taught in graduate programs, such as long-term psychotherapy and working in isolation with the patient.

“We are really needing people who can work in a primary care environment,” Khatri said. It’s a faster pace — 10-to-15 minute sessions rather than 45-minute sessions — for briefer duration, so professionals won’t be seeing a patient for years at a time to manage depression.

A behavioral health consultant has to be flexible and know how to consult with a patient and the primary care team, Khatri said. The work needs to be brief, focused and clinically grounded. Certain personalities thrive in that kind of environment.

“I think if you start from a community-based perspective and you listen to your patients, it only makes sense to evolve a system this way,” Freeman said. “You’ve got to be flexible and you’ve got to be persistent.”

Payers and governmental structures are not presently set up to recognize integrated-care providers. “But it can be done,” Freeman said, “and it needs to be done.” ☺