Behavioral Health Services in Primary Care Settings

Chapter 6

Mental illness and substance abuse disorders are a critical determinant of health and represent an important drain on the economy of rural communities and contributor to health care costs. In 2011-2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that a total of 7.3% of the North Carolina population age 12 or older reported dependence or abuse of illicit drugs or alcohol in the past year.[1] More specifically, 4.9% of the state's population age 12 or older reported alcohol dependence or abuse in the past year,[2] and 2.9% reported illicit drug dependence of abuse.[3] In addition, 3.9% of the state's population age 18 or older reported a serious mental illness in the past year,[4] 6.6% reported at least one major depressive episode,[5] and 16.8% reported any mental illness.[a,6] Some people with mental health and substance abuse disorders fail to recognize or admit that they have a problem. One study showed that 40% of people with major depression either did not want or perceive the need for treatment.[7] Others may be afraid to seek care due to real or perceived stigma.[8,9] Still others who want and need treatment are unable to access it. In 2010-2011, only a little more than 50% of children and adults who needed mental health services, and only about 10% of youth and adults needing substance abuse services were able to access it through the state's publicly-funded mental health system.[10] The Task Force on Rural Health recognized that improvements in behavioral health services are critical to improving both the physical and mental health of people living in rural communities.

Mental Health

Mental health disorders can have a profound effect on an individual, their interpersonal relations, their functioning in schools or workplace, and their overall sense of well-being.[11] The average number of poor mental health days over the past 30 days in rural counties is 3.9 days (95% CI: 3.6-4.2) and 3.7 days in urban counties (95% CI: 3.6-4.1). In Tier 1 counties that number is 4.1 days (95% CI: 3.6-4.5), Tier 2 is 3.9 days (95% CI: 3.5-4.2), and Tier 3 is 3.8 days (95% CI: 3.6-4.1).[b] The 'poor mental health days' measure is based on an individual's response to a survey item indicating the number of days during the last 30 days that he/she feels like his/her activities were limited by mental illness. The relationship between mental health and functional status

As a behavioral health professional, I meet with patients before the primary care visit to introduce myself and screen for depression. I recently had a great discussion about depression with a gentleman who had just screened positive. We brought his primary care provider into our conversation, and the patient agreed to begin medication and continue brief behavioral health work whenever he was in for medical visits. I later met his wife during her check-up, when she explained, "You met with my husband last week – our family has already noticed such a change! I just don't think he would've gotten help had he not been asked about it here!"

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a A serious mental illness is defined as a "diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in serious functional impairment." Any mental illness is defined similarly, as having a diagnosable mental health, behavioral, or emotional disorder that is not a developmental disability or substance use disorder that meets the DSM-IV criteria, but does not result in serious functional impairment. A major depressive disorder is defined as having a period of "at least 2 weeks when a person experienced a depressed mood or loss of interest or please in daily activities and had a majority of specified depression symptoms" as defined in the DSM-IV. Source: SAMHSA. 2011-2012. *National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)*. Tables 23, 24, and 26. Available at: http://www.samhsa.gov/data/NSDUH/2k12State/Tables/NSDUHsaeTables2012.pdf. Accessed July 24, 2014.

b Eleanor Howell, MS, State Center for Health Statistics, North Carolina Department of Health and Human Services, email communication, April 17, 2014

is complex and, at times, subtle. Functional status can be defined as a person's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well being. People with severe mental illness or substance abuse problems often have trouble with work attendance, relationships, or even activities of daily living, and this social isolation is often associated with depression increases the risk of disability.[12] One study conducted in North Carolina demonstrated that individuals with depression had 5.5 times more absent days from work over the last 90 days compared with people without mental health symptoms (11 days versus 2 days).[13] Many people with moderate depression also have chronic conditions and physical limitations. It may be that physical symptoms (such as joint pain from rheumatoid arthritis) lead to depression and that disability results from both. Individuals with pre-existing depression or other mental illnesses tend to fare less well when recovering from injury, illness, or surgery.[14,15]

In North Carolina, the rates of mental health related emergency department visits are far higher in rural counties compared to urban counties.

Having a current mental health illness is one of the most common risk factors for suicide ideation and death. Almost half (47.5%) of North Carolinians who die by suicide had a current mental health illness, with a similar percentage (46.7%) having a history of treatment for mental illness.[16] The rate of suicide is similar in rural and urban communities, with 13.4 per 100,000 deaths by suicide in rural areas (95% CI: 12.0-13.6) compared to 12.8 in urban areas (95% CI: 12.0-14.8).[17]

Emerging research has also shown the impact of mental illness—particularly depression—on the use and cost of health services. People who are depressed or have anxiety disorders have more unexplained medical symptoms than do people without a mental health illness. Depression has been associated with a 50% increase in medical costs for other chronic illnesses, even after controlling for the type and severity of physical illness. Depression has also been linked to longer lengths of stays in the hospital, even after controlling for severity of medical illness, and it has been linked to higher mortality rates for people who have diabetes or heart disease.[18] The increase in physical disease burden among people affected by mental illness supports a more integrated approach in which both physical and mental health care are provided in the same setting and with increased coordination.

Mental health and substance use related symptoms often result in the need for acute medical care. In North Carolina, the rates of mental health related emergency department visits are far higher in rural counties (126.4/10,000 people; 95% CI: 125.1-127.7) compared to urban counties (95.6/10,000; 95% CI: 94.8-96.3). The disparity is greater when comparing Tier 1 counties (129.5/10,000; 95% CI:127.7-131.2) to Tier 3 counties (86.9/10,000; 95% CI:86.1-87.7).[c] The increased cost of physical health care for people with mental illness and the increased use of emergency departments in rural North Carolina

c Eleanor Howell, MS, State Center for Health Statistics, North Carolina Department of Health and Human Services, email communication, April 17, 2014

are important cost drivers and indicate a need to focus on improved mental health care to control costs in both physical and mental health care.

Depression also makes it more difficult to treat or manage chronic conditions, as people who are depressed are less likely to take their medications as prescribed or to otherwise follow their treatment regimens.[17] People who are depressed are also more likely to engage in risky health behaviors including smoking, overeating, and sedentary lifestyles. Depression doubles the risk of death for people with diabetes, underscoring the importance of diagnosis and treatment to ensure optimal medical and mental health outcomes.[18]

Substance Abuse

People with substance abuse problems or dependence are at risk for premature death, co-morbid health conditions, and disability. Furthermore, substance abuse carries additional adverse consequences for the individual, his or her family, and society at large. People with addiction disorders are more likely than people with other chronic illnesses to end up in poverty, lose their job, or experience homelessness. Addiction to drugs or alcohol significantly contributes to the state's crime rate as well as to family upheaval and motor vehicle fatalities. Approximately 90% of the criminal offenders who enter the prison system have substance abuse problems.[8,19] More than two out of five youth in the state's juvenile justice system are in need of further assessment or treatment services for substance abuse.[20] Substance abuse is also one of the primary causes for motor vehicle fatalities, contributing to more than one-quarter (26.8%) of all crash-related deaths.[21] A greater proportion of motor vehicle crashes are alcohol related in rural counties than in urban counties (5.8% rural; 95% CI: 5.6-6.0; 5.1% urban; 95% CI: 5.0-5.2).[22] In addition, alcohol or drug use is a major contributor to family disintegration. Nationally, parental use of alcohol or drugs contributes to more than 75% of cases in which children are placed in foster care. The relationship between substance abuse and injury or illness points to the need to support a more integrated approach.[23]

A greater proportion of motor vehicle crashes are alcohol related in rural counties than in urban counties.

Recently, overdose death rates have skyrocketed in North Carolina. Since 1999, the number of these deaths has increased by more than 300%, from 297 deaths in 1999 to 1,140 deaths in 2011. The majority of these overdose deaths involve prescription opioid pain relievers (like methadone, oxycodone, and morphine). In fact, opioid analgesics are now involved in more drug deaths than cocaine and heroin combined.[24]

Youth are particularly susceptible to the influence of drugs or alcohol, as these substances affect the developing brain. Repeated exposure to drugs or alcohol can alter brain chemistry and microanatomy, making it harder for people to weigh the trade-offs of short-term pleasure derived from drug or alcohol use versus the longer term consequences to the individual and his/her family by the use or misuse of these substances.[25] Use and misuse of alcohol and other drugs is particularly problematic for youth and young adults under age 25. According to the 2011 North Carolina Youth Risk Behavior Survey, about 20% of high school

students have taken a prescription drug without a doctor's prescription.[26] Thus, efforts should be made to target prevention strategies to youth and adolescents.

Delivering more mental health and substance abuse services in conjunction with primary care is an important option for rural communities. Access to mental health and substance abuse services may be limited by virtue of provider supply (discussed in Chapter 8), type and extent of insurance coverage, and stigma. Primary care has become the de facto mental health system for many people with mental health and substance abuse disorders as most people have a primary care clinician, while access to and use of behavioral health specialists is limited.[7] In addition to the lack of behavioral health providers, another limiting factor is insurance coverage. Historically, most private insurers limited coverage for mental health and substance abuse services, either by charging higher coinsurance (e.g. the client pays 50% for mental health services but 20% for other physical health services), limiting the number of visits each year, or excluding mental health or substance abuse services entirely. The Mental Health Parity and Addiction Equity Act of 2008 mandated that large employers provide coverage for mental health and substance abuse services in parity with coverage offered for physical health (e.g. diabetes, asthma), but this law did not extend to small employers or plans purchased in the individual (non-group market).[27] The Patient Protection and Affordable Care Act mandates mental health and substance abuse parity in individual and small group plans.[d] This should mean that, by virtue of insurance coverage, more people are able to access mental health and substance abuse services.

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People with a mental health illness or substance abuse problem often present to primary care providers with pain related complaints, other body symptoms, or uncontrolled medical conditions such as diabetes. Primary care providers need to be able to diagnose, refer, and/or treat people presenting with such symptoms. Perhaps as important, patients may be more willing to consider treatment for a behavioral health condition either by his/her primary clinician or by a behavioral health specialist if it is in the context of a whole person, using an integrated approach to wellness.[28-30] Behavioral health training is a required part of residency training in family medicine, internal medicine, pediatrics, and obstetrics and gynecology.[31] However, the education and experience with behavioral health training varies by discipline and between programs within a discipline. Further, after a primary care provider enters practice, an individual's confidence, competence, and interest may determine scope of practice. Further, meeting behavioral health needs can be time consuming and reimbursement models do not always support whole person care.[32,33]

Incorporating behavioral health services into physical health services is one important component to whole person care, and has been associated with improved quality, improved outcomes (for mental health and physical health),

d Patient Protection and Affordable Care Act. 2010; 111-148:1501.

patient and provider satisfaction, and decreased cost.[29] The quality and consistency of treatment in primary care settings, and the integration with referral specialty services for behavioral health care, are essential to improved behavioral health treatment.

Integrated Care

The NCIOM Task Force on Rural Health, informed by experts on mental health and integrated care, as well as significant evidence from rural communities, chose to focus recommendations for mental health and substance abuse screening and treatment on integrated care. Integrated care refers to either the delivery of mental health and substance abuse services in a primary care context, or the delivery of primary care in behavioral health care settings (sometimes referred to as reverse integration or reverse co-location). Recognizing that the availability of behavioral health care settings in rural North Carolina is limited, the recommendations generally apply to integrating more behavioral health care into primary care settings.

A meta-analysis of 57 studies showed an average cost savings of 20% with integrated care.

Integrated care has been described along a continuum, from minimal collaboration to close collaboration in a fully integrated system. The Task Force on Rural Health recognized that all rural primary health settings are not ready to fully integrate care to the same extent, and that fully integrated care requires culture change, leadership, investment, and additional staff. At the same time, the Task Force recognized that most rural primary health care settings were in a position to move toward more integrated care, and state and local resources should be made available to assist and incentivize integrated care. Even primary health care settings providing the lowest level of behavioral health care should consider adding services such as screening and referral in the context of an increasingly integrated system of care.

Systematic reviews and large randomized controlled trials have shown that behavioral health care integrated into primary care improves symptoms of depression, functional status, and patient satisfaction.[34-37] In addition, integrated care may improve management of chronic health conditions such as diabetes.[38] However, all integrated care is not the same. The evidence base for integrated care has been largely built on studies of close collaboration or fully integrated care. Common strategies were observed in the studies of high quality, successfully integrated care: active management by a primary care clinician, collaboration with a mental health professional, adherence monitoring, treatment response assessment using a symptom checklist, active support for patient self-management skills, and integrated treatment lasting at least 16 weeks.[39] Such integrated care has been shown to be cost effective. Because the management of behavioral health conditions accounts for as much as half of the time of primary care clinicians, integrated care can ensure that the right provider cares for the right condition at the right time. A meta-analysis of 57 studies showed an average cost savings of 20% with integrated care.[40] In a fully integrated system, the relationship with the provider is continuous (similar to

primary care), although the episodes may be time limited. For example, a patient in a primary care setting may have episodic depression during times of stress, and may occasionally need care by a behavioral health specialist. The behavioral health specialist in the integrated setting has an ongoing relationship. With episodic mental illness in mental health specialty care, treatment episodes occur until symptoms remit, then a relationship is effectively terminated. If mental health symptoms recur, that will require a new referral, new approval for services, and sometimes the development of a new relationship with a new office, staff, and behavioral health care specialist.

Approaches to integrated care vary widely, and some variations may be best suited for some clinical settings. The Task Force considered a range of integrated approaches, starting with models that focus on primary care providers (such as screening, brief intervention, and referral into treatment when necessary), to models that fully integrate behavioral health and primary care providers into the same practice. Close collaboration or full integration can still take place even if there are few behavioral health specialists available in a community. This can occur through the use of available part-time behavioral health specialists, consultations with behavioral health providers, or the use of telebehavioral health.

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Minimal Collaboration

Small rural health care practices can expand the availability of high quality behavioral health services even absent full integration. At a minimum, primary care providers should include routine universal validated screening for mental health symptoms and substance abuse. Primary care providers should follow up on positive screenings with a detailed history to assess for presence and severity of conditions. If detailed evaluation by a provider skilled in the assessment of mental health and substance abuse disorders indicates such an illness is present, treatment can be initiated in the primary care setting. Follow up should be assured and treatment response assessed. Validated screening tools exist for a variety of mental health and substance abuse conditions in pediatric and adult populations. These are typically self-administered while a patient is waiting for his or her provider. Many clinics will give patients brief mental health screening tools to complete at the check-in process so that the information is available for the provider at the start of the visit. In many cases, such screening is required or incentivized for reimbursement. However, referral and care coordination may not be required and may be more limited in some settings. People with severe and persistent mental illness or substance abuse should be referred to the specialty behavioral health system. Referral to specialty behavioral health care systems can be a particular challenge in rural settings where mental health providers can be in severely limited supply. This challenge is addressed in Chapter 8 of this report. Care managers can be heavily utilized in this type of integrated care for assessment of treatment response, adherence, and coordination of referrals when needed.

Basic Collaboration from a Distance

A somewhat more collaborative approach occurs when the primary care provider and behavioral health specialist establish a closer working relationship. This can include occasional consultation around more challenging diagnostic or treatment issues. Clinicians still work in essentially separate systems and communication is occasional. The behavioral health specialist generally does not see the primary care patient being treated for a behavioral health disorder in a primary care setting.

Basic Collaboration on Site

Increasing collaboration can occur with regular remote consultation and collaboration around a care plan or onsite collaboration. With co-location, primary care and behavioral health care providers generally care for the same patients in parallel systems under the same roof. Billing is independent. Scheduling is independent. However, co-location helps remove the stigma the patient might otherwise experience in seeking specialty behavioral health services. The patient is just 'going to the doctor's office' thus avoiding behavioral health stigma. The health care providers have more regular opportunity to interact around a patient's care and provide bi-directional support for each other's roles in the team.

Close Collaboration in a Partly Integrated System

Higher levels of integration occur when providers start to share charts, scheduling systems, and billing systems. Providers should also have more regular face-to-face communication and collaboration. This level of integration can occur with intensive telebehavioral health support, allowing for virtual face-to-face visits with patients and communication between providers. Typically "warm hand-offs" can occur at this level of integration. A warm hand-off is when a medical provider introduces a patient to a behavioral health specialist at the time of the visit. This allows for the patient to feel more comfortable coming back to see the behavioral health specialist. The behavioral health specialist can also triage the behavioral health need and ensure follow-up. For example, a patient with palpitations who is thought to be having panic attacks can be introduced to a behavioral health specialist and rapid follow-up assured before the patient leaves the office.

Close Collaboration in a Fully Integrated System

The most integrated care occurs when all systems are shared, collaboration is the norm, and the care occurs continuously for patients with behavioral health needs. Warm hand-offs are the norm, and a primary care provider who identifies a behavioral health need during a visit can introduce the patient to a behavioral health specialist in real time for initial intervention, while coordinating with the primary care clinician around visit wrap up and team-based follow up. This type of integration holds the most promise for increasing the efficiency and satisfaction of the primary care clinician. It also requires the most culture change in practice, leadership, and investment. Further, structural barriers of

traditional fee-for-service care makes this the most difficult to implement in a sustainable manner. For example, some payers will not allow two charges on the same day from the same facility for the same diagnosis. Also, both providers (primary care and behavioral health) are not accustomed the fluidity and scheduling challenges inherent in this more dynamic care model.

The current discussion around Medicaid reform and the proposal from Secretary Wos to the North Carolina General Assembly is an opportunity to invest in integrated care in our state. Specifically, the proposed plan for Medicaid reform recognizes both the improved quality and potential for cost savings with integrated care. Accountable Care Organizations can choose to invest in primary care-behavioral health integration as a means of improving health outcomes and lowering overall health care costs.[41] However, there is no requirement for integrated care. As the Medicaid reform proposal is reviewed by the North Carolina General Assembly and then implemented, partners involved in primary care such as Community Care of North Carolina and experts in integrated care such as the North Carolina Center of Excellence for Integrated Care should work with policymakers and the Division of Medical Assistance to best support the delivery of integrated care and the technical challenges of such integration in rural environments. The North Carolina Center of Excellence for Integrated Care recently co-hosted a policy summit on integrated care in North Carolina. The panelists and practitioners focused on the policy and practice opportunities and barriers within integrated care and formed the following workgroups as a result of the summit: workforce development, data collection/payment model development, consumer engagement, and team building.[e]

In North Carolina, most hospitals are now affiliated with one of 19 health systems. In 2013, there were only 22 (of 126) non-affiliated hospitals.

Medicaid reform is taking place in a state context which includes the rapid consolidation of health systems. In addition, at both the state and national level, there is a movement toward the development of shared savings Accountable Care models. In North Carolina, most hospitals are now affiliated with one of 19 health systems. In 2013, there were only 22 (of 126) non-affiliated hospitals.[42] Many of these health systems are developing contractual agreements with private payers and Medicare around shared savings models. Shared savings programs include a variety of models which shift both the risk and the reward from the payer of services to the provider of services. Such models include pay for performance, bundled payment, and Accountable Care Organizations. A number of such models are a product of reforms, demonstration projects, and incentives under the Patient Protection and Affordable Care Act. There are currently 24 Accountable Care Organizations in North Carolina.[43] The Toward Accountable Care Consortium is a program of the North Carolina Medical Society that includes 39 member organizations. Toward Accountable Care is designed to provide information about Accountable Care Organizations and develop health system and specialty guides around accountable care.

e A video of the summit will be available at http://ncfahp.org/icare.aspx.

Evolving mental health reform is an important context for considering primary care-based or integrated mental health and substance abuse services. Over the past several years, we have seen significant consolidation in mental health managed care organizations (MCOs). These MCOs are the local delivery organization for community-based mental health, substance abuse, and developmental disability services paid for by Medicaid. Since 2009, MCOs in North Carolina have consolidated from 23 to 9.[44] These MCOs provide the behavioral health carve out services to defined groups of Medicaid beneficiaries under contract with the state Division of Medical Assistance, wherein the financial risk remains with the state.[45] The proposed plan for Medicaid reform in North Carolina by Secretary Wos and Governor McCrory call for further consolidation to four MCOs, and continues to carve out mental health from other health services.[41]

Since 2009, mental health managed care organizations (MCOs) in North Carolina have consolidated from 23 to 9.

Use of Evidence-Based or Evidence-Informed Integrated Care Strategies in Rural Communities

In the Task Force on Rural Health rural community forums, we heard about many existing models of successful care integration. Many of these efforts focus on enhancing the capability of primary care providers to meet the behavioral health needs of their patients without full integration. Some co-locate or integrate licensed clinical social workers or other behavioral health providers into primary care or school-based settings. These types of programs should be seen as the foundation for expanding integrated care and moving towards increasingly integrated care. Other organizations use remote behavioral health care providers to deliver care (e.g. telepsychiatry) or consultation and review of cases. The Task Force on Rural Health learned about three exemplar organizations that integrate behavioral health and primary care in rural communities: Community Care of the Sandhills, the North Carolina Statewide Telepsychiatry Program, and The Rural Health Group.

Community Care of the Sandhills

Community Care of the Sandhills (CCS) is in the midst of implementing telepsychiatry in 40 primary care practices over three years to address the recognized shortage of psychiatrists in the CCS region. CCS is providing hardware, a toolkit, scheduling support, and other technical assistance (with grant support from Easter Seals, FirstHealth of the Carolinas, Monarch NC, and the Kate B. Reynolds Charitable Trust). Psychiatrists will schedule two types of visits: one for assessment (1 hour) and the other for consultative medication management (30 minutes). The psychiatrist will bill the insurer independent of the primary care practice.

North Carolina Statewide Telepsychiatry Program (NC-STeP)

In July of 2013, the North Carolina General Assembly funded an initiative to expand statewide telepsychiatry services. Though not focusing on primary care integration, this is an important step in whole person care, and may support expanded reach into primary care such as the current CCS program

(above). The NC-STeP program builds off of the experience of eastern North Carolina, which extended telepsychiatry services to 14 hospitals, resulting in an over 50% reduction in emergency department length of stays for discharge to inpatient mental health treatment, as well as a reduction in emergency department recidivism, involuntary commitments, and readmission to mental health facilities.[46] In addition, rates of patient satisfaction with telepsychiatry services were high. Building on this experience, NC-STeP was funded with appropriations of $2 million per year for two years. Since this program started on January 1, 2014, 18 additional hospitals have begun providing telepsychiatry services (in addition to the 49 hospitals already with in-person or telepsychiatry services in the emergency department).[46]

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The Rural Health Group

The Rural Health Group is a federally qualified health center operating 14 locations in northeastern North Carolina. The center offers fully integrated behavioral health care by psychologists and licensed clinical social workers onsite. The mission of the Rural Health Group is for every patient to have a behavioral health specialist on his or her health care team, just like each patient has a primary care provider and a dentist on his or her team. Real time collaboration and dynamic integration are the norm. In this fully integrated model, a patient's primary care provider and behavioral healthcare provider share a medical record, operate with the same scheduling system, and are supported by the same office staff.

Community-Based Services

Though the Task Force on Rural Health recognized that integrated care is, in some ways, ideal for many people with mental health and substance abuse disorders residing in rural communities in North Carolina, the Task Force also recognized that, in many settings, primary care is also in short supply or limited by cost, distance, and transportation. Thus the Task Force explored evidence-based or evidence-informed community based programs and supports to fill the gap, including Mental Health First Aid; 12 step programs; faith-based support; and Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Mental Health First Aid

Mental Health First Aid is a brief training program designed to teach people about developing mental health symptoms with the goal of early identification, increasing understanding and awareness, offering help in crisis or acute situations, and linking with other resources when appropriate. There is a training program focused on youth as well. Studies of mental health first aid have showed increased reporting of helping behaviors, greater confidence in

providing help, and less social distance from those with mental illness. Mental Health First Aid has been studied in urban, rural, and workplace settings.[47] Mental Health First Aid and Youth Mental Health First Aid Training is widely available in North Carolina.[48,49]

12 Step Programs

12 step programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous, are widely available and highly effective at helping members maintain sobriety. In the United States, an average of 5 million people attend 12 step programs each year.[51] There are over 64,000 AA groups with over 1.4 million members in the United States. 12 step programs are highly effective for frequent meeting goers, with a median length of abstinence of five years for those who attend two to four meetings per week. In addition, 12 step programs have been associated with other important psychosocial outcomes and social connectedness. It is important to note that the success of 12 step programs is highly user dependent, and may be related to an individual's prognosis and social relationships.[51]

The Task Force explored evidence-based or evidence-informed community based programs and supports to fill the gaps.

Faith-Based Support

Faith communities are a critical part and partner of the behavioral health care landscape in many communities. For example, 12 step programs are often housed at or sponsored by faith communities. In addition, psychological first aid training is often targeted at church ministry programs.[51] Furthermore, many congregational leaders and lay ministries are involved in behavioral and mental health support and services which, at times, carry fewer stigmas and offer a religious context that may be more accessible for members of a faith community.[52] One such example is CareNet Counseling, a faith-based service house at Wake Forest University that provides wellness opportunities, education, and counseling in a number of rural communities in North Carolina.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a universal approach to the identification and treatment of alcohol and drug use problems that can be delivered to all patients in a variety of clinical settings, including emergency departments, primary care offices, and health department clinics. The goal of SBIRT is to identify early problem alcohol and drug use behaviors and offer brief treatment or referral as appropriate to mitigate the problem before it becomes more serious. SBIRT has been shown in clinical trials to result in a decrease in problem alcohol drinking, improved overall health, fewer arrests, and more stable housing. SBIRT has also been shown to be a cost effective approach to problem substance and alcohol use.[53]

Recommendation 4: Use Primary care and public health settings to screen for and treat people with mental health and substance abuse issues in the context of increasingly integrated primary and behavioral health care.

a) Community Care of North Carolina, the Division of Medical Assistance, and private payers should provide incentives to encourage primary care medical homes to screen patients during wellness visits for mental health symptoms and substance abuse using validated screening tools. As part of the incentives, practices should be required to offer treatment or referral resources for patients that screen positive and express interest in addressing symptoms.

b) The North Carolina Center of Excellence for Integrated Care, Community Care of North Carolina, North Carolina Pediatric Society, North Carolina Academy of Family Physicians, the Division of Public Health, and other appropriate partners should continue to provide technical assistance to increase both the level of integrated care and the amount of integrated care available in all practice settings, including but not limited to, private primary care practices, health department primary care clinics, FQHCs, rural health centers, and health systems. Practices should be offered technical assistance to help with culture change, the right mix of providers, overcoming billing issues, and financial strategies for success.

1) The Division of Medical Assistance and private payers should evaluate payment policies to promote integrated primary care and behavioral health practices. This would include, but not be limited to, facilitating and allowing behavioral health and primary care providers to both bill for services provided to the same patient on the same day and incentivizing implementation of integrated care through quality initiatives and Medicaid reform.

2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Community Care of North Carolina, the North Carolina Pediatric Society, the North Carolina Academy of Family Physicians, and the North Carolina Foundation for Advanced Health Programs should develop a working group to best support integrated care under Medicaid reform.

3) **Toward Accountable Care Consortium (a program of the North Carolina Medical Society) should work with Accountable Care Organizations and other shared savings delivery models to identify and implement best practices for integrated care to improve quality and decrease cost given the ample evidence that well integrated care does both.**

4) **Health systems and primary care providers should work to develop increasingly integrated care. This should be done working with technical assistance providers and in the context of current payment systems to maximize sustainability of integrated care, but also with attention to evolving payment reform.**

c) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Community Care of North Carolina, and state mental health and substance abuse prevention and treatment organizations (North Carolina chapter of the National Alliance on Mental Illness, Alcoholics Anonymous /Narcotics Anonymous) should develop local resources and capacity for evidence-based and evidence-informed strategies to identify, support, and treat people with mental health symptoms and substance abuse issues, including psychological first aid, peer support, lay health workers, 12 step programs, and faith-based services.**

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