Chapter 3
Integrating Mental Health Prevention into the Primary Care Workflow

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3.1 Introduction

Primary care is first, foremost, and fundamental (Starfield, 1998; Starfield & Shi, 2004, 2007; Starfield et al., 2005). It is the bedrock, the core function of a healthy delivery system. For decades, science has recognized that without mental health as a part of this function, primary care offers inferior and insufficient care. In the seminal 1996 National Academies of Science, Engineering, and Medicine (formerly Institute of Medicine) report on Primary Care, authors described the critical necessity of investing in primary care to help achieve population health goals (deGruy, 1996; Institute of Medicine, 1996). Since then, the healthcare sector continues to work at valuing and investing in primary care, and the integration of mental health has taken a much more visible position in the primary care community, at least conceptually (Brown Levey et al., 2012; Butler et al., 2008; B.F. Miller & Hubley, 2017; Zivin et al., 2017).

The integration of primary care and mental health, as defined by the Agency for Healthcare Research and Quality (Peek, 2013) is the: *Care that results from a practice team of primary care and behavioral health clinicians, working together with*

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patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Bringing mental health clinicians into primary care settings and onto the primary care team has significant benefit for the patient (Balasubramanian et al., 2017). From early detection of mental health problems to crisis intervention and treatment, there are a multitude of gains when mental health expertise is on site in a primary care practice. While the literature has covered the science behind integration in great detail elsewhere (Butler et al., 2008; Funk et al., 2008; Patel et al., 2013), there are two key aspects of the work that we will consistently refer to in this chapter. The first is the importance of workflow and assuring that pathways for the patient and all the clinicians involved in care are clear and consistently defined so that patients do not get lost in the system or fall through the cracks (Davis et al., 2013). The second is the range of interventions that mental health clinicians provide on the primary care team (Maragakis & O'Donohue, 2018; B. F. Miller et al., 2014). We posit that prevention and early intervention should be a core foundation of how primary care conceptualizes and implements its integrated model. This chapter will explore the need and growing effort to better integrate mental health in the primary care setting, which includes identifying ways that core prevention services can be distributed in the clinical workflow to improve care and efficiency as well as provide specific recommendations for mechanisms that can be employed to improve integration efforts among practice personnel, and system and policy changes needed to facilitate changes in the clinical setting.

3.2 Defining Prevention

Across the globe, health prevention and healthcare delivery are typically divided into three tiers: primary, secondary, and tertiary. Each tier has a unique and overlapping clinical workflow, with bidirectional flows of patient information, provider tasks, and levels of communication. Here we will briefly describe the various types of prevention.

Prevention in the primary care setting was first defined in the 1940s by Hugh Leavell and E. Guerney Clark of Harvard and Columbia Schools of Public Health as "measures applicable to a particular disease or group of diseases in order to intercept the causes of disease before they involve man…" (Cohen et al., 2010, p. 5). Primary caregivers include primary care physicians (PCPs), nurse practitioners (NPs), and physician's assistants (PAs). The primary care setting is the first point of contact for people who need healthcare and healthcare services for routine services such as vaccinations and occurs before the development of illness or disease.

The literature has robust examples of primary prevention – and many of the solutions for advancing health and preventing disease are grounded in social or

community factors. If the goal of primary prevention is to avoid the onset of the disease to begin with, this means that most of the priority factors for intervention are social factors like where a person lives, their education, and their employment, also referred to as the social determinants of health (SDoH).

Mental health clinicians working in primary care will have appointees, which may range from patient navigators to social workers, to address the above issues through a network of care model. Prevention in secondary care requires a screening element and involves more clinicians and treatment than primary and is typically hospital-based. It can be routine and planned, like mammography or colonoscopy, or it can be urgent, like treatment of a fracture or severe stomach flu. Prevention in tertiary care is the highest specialization of care and occurs after diagnosis of a disease or illness, for example, neurosurgery for a brain tumor or chemotherapy for cancer patients (Centers for Disease Control, 2019).

3.3 Public Health Prevention

Public health prevention focuses on prevention of disease and health promotion, and provision of a limited set of safety net services – often outside of the primary care setting and not providing the full set of services that would be classified as a medical home, let alone robust integrated care that includes mental health services. Access to more comprehensive health and mental health services usually require referral, though there are some local and regional public health clinics that provide a wider array of services and might be considered integrated in some ways. Those clinics are sometimes affiliated with a Federally Qualified Health Center or co-located with state-level services (such as Women, Infant & Children programs).

3.4 Prevention in Primary Care

The literature is clear that having a regular source of care is the single most important factor associated with the receipt of preventive services (Bindman et al., 1996). Primary care at its core is about continuity (Schwarz et al., 2019) and comprehensiveness (O'Malley & Rich, 2015). In fact, Barbara Starfield in her seminal work on primary care (Starfield, 1998) described how comprehensiveness in primary care must include prevention and wellness, as well as acute and chronic health condition management, which includes mental health. As others have written, bringing mental health into primary care only complements these core functions of continuity and comprehensiveness (Dickinson & Miller, 2010).

Despite the hurdles, prevention matters, as it is fundamental to improving both personal and population health outcomes. Prevention means avoiding more intensive and costly services, improving quality of life, increasing productivity, and reducing morbidity/mortality outcomes (Hogg et al., 2008; HUNG et al., 2007).

Subsequent to the passage of the Patient Protection and Affordable Care Act (ACA), most health plans are required to cover preventive services, though plans vary greatly in which of those services they cover (Fox & Shaw, 2015). For the most part, preventive services include items like blood pressure, diabetes, and cholesterol tests as well as certain screenings for cancer. Specific to mental health, depression screening is the *only* item considered covered under prevention ("Preventive care benefits for adults," 2021). One of the ongoing critiques of prevention practices in primary care has been on the amount of time it takes to deliver those services. In an often-cited paper, Yarnall et al. (2003) indicated that, in the hustle and bustle of delivering primary care, to "fully satisfy the USPSTF recommendations on prevention, 1773 hours of a physician's annual time, or 7.4 hours per working day, is needed for the provision of preventive services" (p. 635). Since 2003, though some improvements have been made in delivery, there remains an increasing number of duties being assigned to primary care clinicians – all important, and all time-consuming. In fact, Bucher et al. (2016) found that the annual time required for primary care to adequately perform all the required preventive care was 20% of their total patient time or about 250 h. And perhaps most interesting, almost three quarters of the patients in this study had a prevention to care time ratio exceeding 15%. The challenge for primary care is made worse through primary care payment structures – particularly with respect to fee-for-service (FFS) contracts that incentivize volume, which artificially creates an inferior care model because primary care providers are beholden to seeing an increased number of patients due to insurance billing structure. FFS contracts translate to shorter office visits to allow the clinician to see more patients, without covering the depth and complexity that some patients require, especially with respect to mental health. As we will discuss in our policy recommendations, FFS models in primary care are an impediment to pursuing both integration and prevention and a factor that must change.

While primary care practices are being asked to do a lot in the prevention space, all health plans offered through the ACA's marketplace are required to cover preventive services without charging patient copays or coinsurance. For example, alcohol misuse screening and counseling as well as depression screening are both covered. Despite the availability and reimbursement of standard screening tools and coverage (meaning payment), for administering screening, most primary care practices still do not screen for depression – less than 5% nationally (Ayse Akincigil & Elizabeth B. Matthews, 2017). It is already hard to treat what you don't see, and without a significant uptake of screening, the progression of mental health conditions will continue to worsen individually and at a population level.

3.5 Mental Health and Primary Care Prevention

Mental health prevention ensures that all individuals have access to the full continuum of whole-person care, no matter how they come into contact with a health system – whether primary, secondary, or tertiary (Well Being Trust, 2020a).

Increasingly, mental healthcare and support is found in primary care settings, as the first line of clinical care for people across the United States (Institute of Medicine (US) Committee on the Future of Primary Care, 1996). As a result, in the last decades, research and investments have increasingly targeted primary care settings as opportunity zones to bring in mental clinicians. It is at this intersection that the opportunities to leverage mental health clinicians comes into focus. First, there are the opportunities for mental health clinicians integrated into primary care to free up more time for the primary care physician. In one study, Polaha et al. found that when a mental health clinician was on site in primary care, primary care physicians spent two fewer minutes on average for every patient seen, allowing them to see 42% more patients, and bring in $1142 more revenue per day. Of course, this was compared to the days the mental health clinician was not on site (Gouge et al., 2016). And when patients have mental health as a primary reason for coming into the practice, they spend an average of 7 min longer when compared to patients in the clinic for non-mental health reasons (Cooper et al., 2006).

Prevention for mental health conditions is often predicated on actually detecting risk factors and symptoms early. Early detection of mental health conditions is critical for young people, ages 13–18, as by age 14 half of mental health concerns and illness first emerge (Dougherty et al., 2020). Healthcare utilization patterns for adolescents underscore the benefit of a mental health vital sign. Many adolescents don't engage in well-care visits as frequently as they do at younger ages, outside of physicals for sports or school requirements –making screening at every opportunity, whether for sexual health or urgent care service, crucial. As we will discuss in our recommendations, keeping this population as a focus in the workflow is an essential way to prevent and treat serious mental illness before it worsens.

Beyond screening for specific mental health conditions, emerging mental health practice suggests that primary care settings are primed for screening for Adverse Childhood Experiences (ACEs) and long-term toxic stress. ACEs was first coined in a 1998 Centers for Disease Control and Kaiser Permanente study (Felitti et al., 1998), in which over 9000 respondents identified if they had experienced one or more of seven categories of adversities (including abuse, traumatic experiences, neglect) by age 18. ACEs have now been expanded into ten categories across three domains, as outlined below:

Abuse: Physical, emotional, and sexual abuse

Neglect: Physical and emotional neglect

Household challenges: Growing up in a household with incarceration, mental illness substance dependence, absence due to parental separation or divorce, or intimate partner violence

With respect to mental health, increased exposure to ACEs activates youths' biological stress response, can damage brain development, and disrupt healthy stress and hormonal regulation patterns. All of these are part of a toxic stress response that has both direct and indirect relationships with outcome such as depression, anxiety, PTSD, and, worse, risk for suicide. As discussed later in the chapter, ACEs can and should be addressed in integrated care settings and through changes in the clinical workflow.

3.6 Evidence

Evidence suggests that prevention is most successful when delivered consistently and with appropriate follow-up (Doyle et al., 2013). In the context of integrated care, this means assuring there is sufficient coordination among providers from screening to treatment. Similar to many of the conditions screened for in the primary care setting to identify physical health concerns, prevention continues to play a role even after screening or test results signal a concern or a diagnosis. For example, screening for cholesterol levels that indicate increased risk is often managed through changes to diet or medication in an effort to prevent more serious outcomes, such as stroke or heart attack. Similarly, primary and secondary prevention are also essential in the management of mental health conditions, such as anxiety, depression, and substance use disorders. Treatment for these mental health conditions can improve a variety of factors, with the ultimate goal of preventing Deaths of Despair (DoD) – as all continue to rise at unsustainable rates (Pain in the Nation, 2020). Primary care clinicians should be able to identify common mental health issues such as anxiety or depression. With identification, they can either collaborate with an embedded mental health clinician for treatment or, if needed, refer patients to specialty care.

Prevention and integration of mental health in primary and secondary care settings have multiple benefits for clinicians and patients:

- Operationalizing the identification and treatment of mental health issues across the spectrum thereby preventing disorders from escalating into more serious mental health issues. For example, a recent investment and evaluation from the Well Being Trust, in which six primary care clinics in Orange County, California, integrated mental healthcare, demonstrated that patients with severe to moderate depression enrolled in systematic screening had between 24 and 28% clinically significant improvement in their symptoms (Well Being Trust, 2020b).
- Physicians report feeling more comfortable talking to patients about their mental health concerns and connecting them with embedded mental health clinicians.

3.7 Importance of Workflows and Evidence on How They Best Work in Integrated Settings

According to the Agency for Healthcare Research and Quality (AHRQ), a clinical workflow is “the sequence of physical and mental tasks performed by various people within and between work environments. It can occur at several levels (one

person, between people, across organizations) and can occur sequentially or simultaneously (AHRQ)." Good clinical workflows can provide better quality of care, deliver improved outcomes for patients, and control or reduce costs of care (Ross KM, et al. 2018; Davenport, et al. 2017). The overarching goals of clinical workflows are to deliver seamless, integrated mental healthcare, and build a system of trust between patient, clinician, and BHC. Examining workflow to address prevention in primary care includes considering how integrated mental health supports these goals to avoid disorganized and under-resourced clinical teams or, worse, failing to identify and provide treatment across the spectrum of mental health services, from prevention to serious mental illness.

Best practices for clinical workflows in primary care clinics have been identified, whether the clinic is at the beginning stages of integration or in a more advanced stage. These best practices are outlined in one of the most comprehensive studies to date, "Clinical Workflows and the Associated Tasks and Behaviors to Support Delivery of Integrated Behavioral Health and Primary Care." This comprehensive analysis, in conjunction with prior research from Davis, drew from two different studies focused on integration of mental health and primary care, *Advancing Care Together* and the *Integration Workforce Study*, and identified four key phases critical to prevention in clinical workflows in integrated care settings across a range of characteristics in practices (Davis et al., 2019). See Table 3.1.

Within each of these phases of clinical workflow design, it is essential to determine who is accountable for each step and have a clear understanding of how each of the phases is interconnected. For example, to systematically screen for mental health concerns, teams must identify which patients will be screened, how often patients will be screened, where and how patients will be screened, who will evaluate or score the screening tool, where will this information be stored in the electronic health record, and who on the team is responsible for follow-up and referral tracking. From this example, it is evident that the actual treatment or clinical intervention provided to the patient though clearly important is only one step in the treatment pathway. A team of individuals on staff with clearly identified roles and responsibilities sets the clinician up with the data and process required to put the patient in the right place to receive the right intervention from the right person.

Team-based care is at the heart of all of the phases of a sustainable workflow (Bodenheimer et al., 2014). Systems for communication between mental health clinicians, PCPs, and staff are essential to providing whole person care and creating the opportunity for multidisciplinary care in a shared setting. Onboarding and training new staff in an integrated setting assures that staff understand not only their unique role in patient care but the value of mental health integration and prevention. Communicating expectations and anticipating challenges in daily team huddles allow high functioning teams to be proactive versus reactive during busy clinic sessions (Stewart & Johnson, 2007). This routine communication also creates space for teams to reinforce protocols or adjust them when exceptions with individual patients arise. The ideal is working toward each individual on the care team, including front desk staff, medical assistants, clinicians, and ancillary providers, who are being utilized and functioning at the highest level of their licensure. Every individual

Table 3.1 The four phases of clinical workflows

Phase	Components
Identifying patients needing integrated care	Systematic mental health screening with clinician discretion for follow-up Use mental health as a vital sign and systematic screening of depression/anxiety, substance misuse, and unmet social needs/basic needs Develop and implement timing protocols for screening intervals and who performs screening (e.g., bi-annually through entry paperwork or by medical assistants) Schedule morning meetings in teams/"huddles" to develop integrated patient care strategy, including deciding on follow-up for rescreening
Engaging patients and integrated care team	Communicate with patient about integrated care and working with mental health clinicians using scripts: describing transition of care clearly and what next steps include, explaining commitment to "whole person care" and trust in mental health clinician as a counselor and colleague Train new and auxiliary staff early on (1) how to explain transition and how to answer questions that may arise and (2) briefing mental health clinicians outside of the clinical room with respect to patient needs
Providing integrated care treatment	Mental health clinicians conducting rapid and focused assessment based on team huddles or EHR information Mental health clinicians create a shared care plan, so that all clinicians understand goals, timeline, and respective responsibility for patient Mental health clinicians are responsible for facilitating correct tier of care, if primary care setting was not enough – establishing a continuum of care for the practice Mental health clinicians must have access to all EHR systems with patient records Mental health clinician practice and integration is reflective of the patterns of primary clinic
Monitoring immediate treatment outcomes and adjusting treatment	Mental health clinician and PCP agreed upon scheduling and follow-up with specialty care More comprehensive EHR records, with complete team access to include patient-level clinical and process outcomes

Adapted from "Clinical Workflows and Structural Workflows that Facilitate or Impede Deliver of Integrated Care"

contributes to patient care and patient experience and has a unique set of skills to contribute to improved patient outcomes.

3.8 Recommendations to Support Prevention in Integrated Health Settings

To ensure widespread adoption of integration and prevention into the clinical workflow, innovation is necessary at multiple levels. Recommendations for supporting prevention in integrated settings are broken down into three categories: clinical,

system, and policy, to operationalize and incentivize individual practice change and a broader redesign of mental health service delivery.

3.8.1 Clinical Recommendations

1. **Redesign Workflow:** The benefits of team-based care are well documented and include improving outcomes while decreasing costs and increasing revenue (Coleman & Reid, 2010). A 2006 evidence review of diabetes interventions found that providing team-based care was the single most effective intervention in improving intermediate diabetes outcomes (Shojania, et al., 2006). Most physicians only deliver 55% of recommended care, and 42% report not having enough time with their patients (Bodenheimer, 2008). Providers spend 13% of their day on care coordination activities and only half of their time on activities using their medical knowledge (Loudin, et al., 2011). Many care and care coordination activities can be better provided by non-physician members of a care team (Coleman & Reid, 2010), and the following steps can help clinics move toward better integrated care that promotes prevention and maximizes personnel time and skill.

    - Engage all staff in integration efforts to promote consistency and standards across clinical personnel and reduce single points of failure.
    - Organize a multidisciplinary team with representation from each unique function within the clinic to develop redesign of workflow – front desk staff, clinical provider, mental health clinician, care manager, clinic administrators, and other roles that may contribute to care and operations.
    - Examine *current* workflow of how a patient experiences integrated mental health, including prevention, through a process mapping exercise. This process map should include every step from the point a patient enters the clinic setting to the time when they leave, including but not limited to screening, entry of screening results into the EHR, warm handoff from rooming staff to medical provider, clinical services provided, warm handoff from medical provider to mental health clinician, external referrals, and closing the communications loop on external referrals. Clearly identify (1) what are the steps in the process, (2) who is accountable for each of those steps along the way, and (3) where are results of each of these steps documented so that other members of the care team can access them for patient care. This exercise provides an opportunity to clarify assumptions that exist as well as identify possible redundancies and gaps in the *current process.*
    - Clinical workflow to support prevention efforts should include considerations related to coding and billing. Staff should be trained on appropriate codes and have a systematic approach to using appropriate billing codes. Including this element in process mapping and workflow design will assure that practices bill and receive claims to cover the services that are being provided. Z codes

are a subset of ICD-10-CM codes that can be used to help identify non-medical factors that may influence a patient's health status. Often characterized as codes that classify "social determinants of health," Z codes may hold great value in identifying factors key to prevention efforts. Though not widely used by clinics and hospitals, most likely because there is limited payment for reporting Z codes, the American Hospital Association (2019) has promoted their utility in the clinical setting – indicating that collecting this information can help providers easily identify social factors impacting prevention goals at the individual level and can be aggregated at the practice level to help inform staffing needs or identification of community resources outside of the clinical setting which might contribute to preventive efforts.

- Working from the current state, map out the *ideal* workflow for the existing clinical staff structure and/or identify where additional personnel might be necessary to better optimize integration and address prevention.
- Provide training to all staff on new processes. Ensure that each staff person can recognize the importance and benefits of prevention and their role in helping patients receive optimal care that include preventive strategies. All staff should have perspective on the workflow from beginning to end and understand responsibilities within their distinct role to ensure success of integrated care delivery that includes prevention.
- Implement changes and revisit with staff on a periodic basis to assess what is working, what additional changes might be needed, where there are gaps in knowledge and skills that require additional training or support, and if the workflow is contributing to intended outcomes.
- Implement daily care team huddles to revisit workflow, look at the day's schedule, anticipate potential needs for mental health clinicians, anticipate potential challenges that could slow the workflow or result in longer appointments, etc.

2. **Maximize Electronic Health Records (EHR):** Facilitating access to relevant patient information across all providers via EHR within the clinical setting to help to reduce redundancy in collecting and documenting patient history and background on the presenting need. This efficiency within the workflow helps to maximize the encounter and save effort in updating patient charts but also helps ensure that all providers have common access to screening, diagnosis, and treatment details.

- Implement systematic mental health screening that populates in the EHR as a vital sign. Easy access to this information at every encounter helps to assess any changes in mental health status that may be crucial for early identification and intervention purposes.
- Establish a dashboard that includes metrics to track intended outcomes, including process measures (number of patients screened, number of patients referred to BHC), outcome measures (clinical quality measures), and patient satisfaction. Prevention is often difficult to quantify and measure, but improving or stabilizing screening results, medication adherence, and comparing practice rates to state or national metrics on timely follow-up can support tracking prevention efforts.

3. **Structure Staff to Promote Integrated Care and Mental Health Prevention:** Hire staff with mental health expertise to ensure that patients have access to meet whole-person health needs. This supports improved health outcomes and frees up primary care providers to focus on their area of expertise. Of note, if access to mental healthcare staff is limited in the clinical setting, e.g., only having mental health clinicians available certain days of the week, scheduling is an important factor to consider as relates to access. Scheduling patients with expressed mental health concerns, those with more complex mental health needs (like medication management), or those with a previous concerning vital sign level on days during which the mental health provider staff is on site, may require the attention of schedulers in cooperation with the clinical team to coordinate accordingly.
4. **Leverage Telehealth:** Use technology, as appropriate, to improve access to care. The success of integration and collaborative care is predicated on having a sufficient workforce to meet the need. This is a challenge in some rural areas where mental health providers are not physically located and urban centers where demand for services may exceed supply of available providers. Increasingly, models of providing telemental health are expanding to improve access and incorporate mental health prevention in rural or medically underserved areas, and staffing needs to facilitate this functionality should be considered when designing the processes to reach patients with limited access to in person services (Waugh et al., 2019).

3.8.2 System Recommendations

1. **Diversify Payment Structures:** The most important system change recommendation to address mental health prevention is to shift the way we pay for care. Research has shown that there are alternative payment models that can support mental health integration, including prevention (Ross et al., 2018). Instead of fee-for-service (FFS), as discussed earlier, payment models that support a team-based approach allow aspects of care to be distributed across the team to appropriately leverage staff time and skill sets, maximize level of training and expertise, and increase efficiency. Distributing aspects of care across the team streamlines service provision and allows primary care and mental health providers to focus on clinical responsibilities during encounters, promoting comprehensive care while increasing their bandwidth to see more patients. New payment models can further support uptake of mental health preventive services. Medicare Advantage, an option for Medicare beneficiaries to choose to receive their benefits through a private health plan instead of the federally administrated program, is one example of a program that allows for more flexibility in what services are rendered and how care is delivered specifically because of the payment mechanism. Medicare Advantage plans are given a specific dollar amount for services, which

allows these plans to be more creative with their providers and more inclusive of services that may not always be covered, like mental health prevention.

2. **Reimburse Networks of Care:** As discussed previously, there are opportunities for mental health clinicians to work on primary and public health prevention. Traditionally, primary care physicians and mental health clinicians are not trained or paid for helping a person connect to social services including applications for vouchers for affordable housing, childcare supports, or SNAP/EBT programs. Primary care clinics are essential but not sufficient to address the complexity of all mental health needs – they need to establish ties with broader networks of care in which BHCs work closely with an interdisciplinary group of providers and supports. Studies show that health outcomes improved for patient populations who were receiving whole-person care, in which referrals and follow-up with social services were integrated into workflows (Hewner et al., 2017). This is particularly important for underserved and under resourced populations, who need a community-based network of care to address interconnected basic and mental health needs. The clearest way to do this is through incentivizing network of care models. Our payment system should move toward a place where clinics can employ mental health clinicians and support staff who can address, navigate, and bill for these types of critical interventions.

3.8.3 Policy Recommendations

1. **Promote Policy Focused on Outcomes:** Though there are opportunities to improve prevention through innovation in the clinical setting, clinical practice and workflow is, in part, structured in response to payment mechanisms. As a result, "prevention" has traditionally fallen outside of the scope of clinical service delivery, as there is often no payment that directly correlates to that aspect of care – despite evidence that investment in prevention improves both morbidity and mortality and can yield savings to the healthcare system. The relationship between care and payment methodology is particularly complex with mental health – as certain codes are not paid unless there is a mental health diagnosis. Due to demands within a primary care visit (Harris, 2015), focusing on screening and prevention for mental health when there is no payment is often not feasible. To advance prevention efforts within the clinical setting, we must acknowledge the role of payment in the organization of care delivery and design policy that allows for payment of care coordination, integration, and implementation of payment models that incentivize screening, prevention, and early identification/treatment. Policy related to healthcare financing at the federal and state level can establish the parameters necessary to restructure payment methodologies and ultimately allow clinical practice to move toward a more integrated approach that prioritizes prevention. Examples of policy action include:

- CPT codes used in Collaborative Care Models (CoCM) should be covered by all insurers at a rate that incentivizes adoption of mental health integration (BHI) models in the primary care setting. Investment at the federal or state level for the technical assistance necessary to better position practices and health systems to fully implement integrative models is also necessary to establish the structure and personnel necessary to successfully adapt workflows.
- The federal government should ensure that hospital payment models and quality programs incentivize assessing mental health at every interaction as a vital sign and not only during well visits. This should include integrating screening and treatment into episode-based payment models for health conditions for which there are frequent mental health comorbidities, such as cardiovascular diseases, cancers, and pulmonary diseases (Well Being Trust, 2020a).

2. **Establish Quality and Measurement Standards:** In addition to advancing financing mechanisms which value prevention, policy can play a role in establishing standards and practices that help promote integrated care that can help prevent crisis and improve patients' mental health outcomes.

- **Access**. Federal law increasingly supports effective preventive care in mental health, with policies such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) in Medicaid or the requirement that most insurers cover certain services recommended by the US Preventive Services Task Force. Unfortunately, these policies mostly support screening for early detection of mental health conditions and have not translated well for young children. Although the American Academy of Pediatrics recommends screening for depression in young children and developing psychosocial needs, coverage for interventions to address these identified needs is inconsistent and often unclear – often failing to ensure that children get access to clinically indicated care. (Well Being Trust, 2020a).
- **Training**. Every year, thousands of new primary care providers enter the field – the vast majority of whom receive little to no training on integrated care (Blount & Miller, 2009; Martin et al., 2019). For those already in practice, few receive any support in learning new skills and practice models for integrated care. Mental healthcare is not so different than the countless other health conditions that primary care providers deal with, but without training, effectively addressing it becomes an unreasonable expectation. Structured training opportunities for those both pre-service and in-service is critical for making mental health a standard part of primary care.

– The federal government should provide incentives, through Graduate Medical Education (GME), Graduate Nursing Education (GNE), and other programs, for healthcare practitioner education institutions to offer training in integrated mental healthcare.
– Providers should be incentivized to take additional Continuing Medical Education (CME) classes on current best practices.

– The federal government should focus existing federally funded quality improvement organizations on mental health integration across diverse primary care practices and for serving diverse populations and financing additional learning collaboratives as necessary (Well Being Trust, 2020a).

3.9 Conclusion

Prevention is key to improving health outcomes and maximizing healthcare spending in the United States. Focusing on prevention and early intervention efforts is as critical for mental health as other physical health conditions. Creating mechanisms in the clinical workflow to capitalize on primary, secondary, and tertiary prevention opportunities benefits both patients and providers. Practice structure and payment models to support screening/identification, proper training for providers, integration to maximize clinical skills, and innovation to reach underserved populations must be considered and appropriately financed to promote prevention and realize improvement in mental health outcomes.

3.10 Resources

The following resources and tools may be helpful to practitioners and healthcare administrators in the implementation of best practices related to mental health integration and ensuring that prevention is a key consideration in structuring the clinical workflow.

- CMS Medicare Learning Network Behavioral Health Integration Services Booklet: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- AHRQ Workflow Tool Examples: https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/examples
- AHRQ Workflow Tools: https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools

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