

The Current State of Behavioral Health in Primary Care for NH Youth

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NHMCAP is part of the portfolio of work of the NH Pediatric Improvement Partnership (NH PIP). The NH PIP is a collaboration between the Children’s Hospital at Dartmouth and IHPP. We would like to thank Dr. Erik Shessler for his guidance on all NH PIP projects. We would also like to thank our partners at NH DHHS Maternal Child Health Section, Erica Tenney and Lauren Holden, for championing this work.

UNH Land, Water, and Life Acknowledgement

As we all journey on the trail of life, we wish to acknowledge the spiritual and physical connection the Pennacook, Abenaki, and Wabanaki Peoples have maintained to N’dakinna (homeland) and the aki (land), nibi (water), lolakwikak (flora), and awaasak (fauna) which the University of New Hampshire community is honored to steward today. We also acknowledge the hardships they continue to endure after the loss of unceded homelands and champion the university’s responsibility to foster relationships and opportunities that strengthen the well-being of the Indigenous People who carry forward the traditions of their ancestors.

Notes

This assessment is focused on the primary care setting and does not include the integration of primary care services into mental health facilities. For the purposes of this report, “youth” refers to children and adolescents under the age of 18.

Contents

- Executive Summary _____ 4
- Background _____ 5
- Project Approach _____ 6
 - Purpose _____ 6
 - Methods _____ 6
 - Survey _____ 6
 - Semi-structured Interviews _____ 7
 - Claims Data _____ 7
- Study Outcomes _____ 9
 - Prevalence of Youth Behavioral Health Conditions in NH _____ 9
 - Role of Primary Care in Treating Youth Behavioral Health _____ 11
 - Behavioral Health Services Provided and Billed by Primary Care _____ 12
 - Barriers to Providing Behavioral Health Treatment in Primary Care _____ 16
 - Role of Teleconsultation in Expanding Primary Care Capacity _____ 17
- Discussion _____ 20
 - Limitations _____ 20
 - Recommendations for Future Study _____ 20
 - Closing Thoughts _____ 21
- References _____ 22
- Appendix A: Study Methods Detail _____ 23
- Appendix B: Survey Tool _____ 24
- Appendix C: Semi Structured Interview Protocol - Primary Care _____ 28
- Appendix D: Semi Structured Interview Protocol - Payer _____ 30

Executive Summary

A shortage of specialty providers and numerous barriers to care access have resulted in a lack of essential youth behavioral health care in New Hampshire. Over the past decade, there have been efforts across NH to address this through Behavioral Health Integration (BHI), from multi-year initiatives to practice-level training or self-funded quality improvement projects. Despite the best efforts of many, the resulting increase in service capacity has been extremely limited. In order to inform future work in BHI, this assessment compiles the experiences, thoughts, and beliefs of primary care professionals and payers pertaining to the current availability, delivery, and payment methodologies of behavioral health services in primary care.

The team used three methods to paint a current picture of the state of youth mental healthcare: semi-structured interviews, surveys, and healthcare claims analysis. Primary care providers (PCPs), clinical teams, and insurance providers [payers] shared their perspectives on the current state and possible future of mental health care in the state through an online survey and a series of virtual semi-structured interviews. To enhance the picture, the Center for Health Analytics at the University of New Hampshire performed an analysis of pediatric health care claims data.

Findings show a clearer picture of the state of youth behavioral health in NH primary care:

- According to claims analysis, **17% of children and adolescents** covered commercially or by NH Medicaid **had an indication of a mental health condition**.
- Interviewed and surveyed PCPs and payers agree that **mild to moderate cases of depression, anxiety, and ADHD can be diagnosed and treated in primary care**.
- Analysis of pharmaceutical claims shows that **PCPs prescribed almost half of mental health prescriptions** for NH children and adolescents.
- Interviewed and surveyed **PCPs face a variety of barriers to providing behavioral health treatment**, including lack of time and access to consultants and specialists.
- According to surveys and interviews, most **practices have at least one behavioral health focused role**, but it varies widely.
- Claims analysis shows **overall low utilization of BHI codes** except for developmental screening.
- Interviewed and surveyed **PCPs are interested in the potential for teleconsults and Collaborative Care to alleviate these challenges**.

While there are some limitations to this assessment, it provides an improved understanding of the current state of care and can serve as the starting point for stakeholders to move forward in a coordinated manner. Given that just four payers cover the majority of NH children with an indication of a mental health condition, NH stakeholders are uniquely positioned to improve access to behavioral health care via primary care.

Background

Lack of access to mental health treatment for children and adolescents is a major public health problem in New Hampshire (NH). While demand continues to grow, the existing behavioral health system does not have the capacity to provide timely services. For example, in 2020 and 2021, less than half of NH kids who needed professional mental health treatment received it.³

A number of systemic barriers contribute to difficulty accessing services. These include lack of or inadequate insurance coverage, location and dispersion of specialists, and a shortage of specialized providers. Nine of the ten counties in NH are designated as having a severe shortage of Child and Adolescent Psychiatrists (CAPs) and one county has none at all.⁴ Before the COVID-19 pandemic, NH was ranked second in the nation most impacted by workforce shortages, which has only been further strained by the pandemic, especially in healthcare.⁵⁻⁶ Workforce limitations contribute to access challenges in several ways: lengthy wait lists, limited appointment flexibility, lack of provider choice, and long drives to access care. NH stakeholders have been working extensively on the entire Children's System of Care for mental health, with a particular focus recently on the specialty mental health care system. The integration of mental health care into primary care is another opportunity to improve access to care for NH youth.

BHI refers to collaborations between PCPs and specialty care providers for a whole-person approach to care.⁷ It has been proven to lessen barriers to care access for children, adolescents, and their families.⁸ BHI is not only a feasible approach to meet the challenges of NH's healthcare system, but has been shown to improve both mental health outcomes and other health conditions in patients with mental health needs.^{2,9} Evidence also shows that BHI improves patient experience and population health while reducing cost.⁸

There have been several efforts to implement BHI across NH, both on a statewide and practice level. Federally Qualified Health Centers (FQHCs) and FQHC look-alikes across the state have been embedding behavioral health clinicians and psychiatric providers for decades. Other practices have partnered with behavioral health clinics to offer co-located therapy. Still others have integrated primary care services into outpatient behavioral health for patients with severe and persistent mental illness. At the statewide level, the New Hampshire Citizens Health Initiative sponsored the NH Behavioral Health Integration Learning Collaborative, a group of varied stakeholders gathered to share their findings and experiences treating depression combined with other chronic conditions.⁹

The most important catalyst for BHI in NH was the Building Capacity for Transformation Section 1115(a) Medicaid Demonstration Waiver, approved in 2015.¹⁰ The goal of the waiver was to improve care for Medicaid patients with behavioral health needs. It required that each of the state's seven regions develop projects focused on BHI.¹⁰ Over a five-year period (2016-2021), all regions developed and expanded BHI initiatives through CMS funding and collaborative learning opportunities. However, it is not clear whether they were continued, and to what extent, beyond the Demonstration period.

The goal of this assessment is to evaluate the current state of pediatric BHI in NH. The Current State Assessment will allow stakeholders to more clearly understand the current barriers to BHI as well as key facilitators, gaps in care, and opportunities within the state. All of these tools can be used to advance the state of youth behavioral health care in New Hampshire.

Project Approach

Purpose

To evaluate the current state of BHI being provided to youth in primary care across NH, the project team gathered insights from providers and non-providers in pediatric primary care environments as well as payers that cover children and adolescents throughout the state. The team sought to understand the thoughts and experiences of the sampled participants in the following areas:

- Expectations of PCPs about assessment and treatment of behavioral health conditions
- Policies, workflows, and team member roles in the practice
- Gaps and opportunities in service delivery
- Billing and reimbursement for integrated care services

Methods

Three methods of data collection were used to gather qualitative and quantitative data: an online survey, semi-structured interviews (SSIs), and analysis of health care claims data.

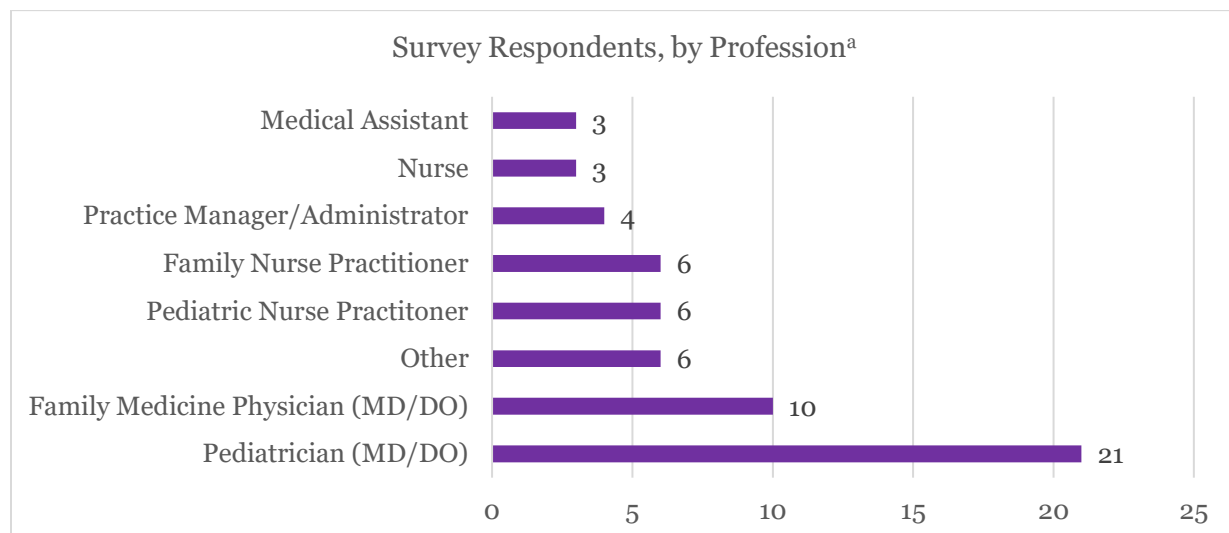
Survey

The survey targeted people who work in NH primary care settings that care for children and adolescents. A total of 59 respondents completed the survey.

Survey Demographics

A total of 59 respondents completed the survey, which limited the ability to further analyze responses by demographic characteristics of the respondents. As shown in Figure 1, the majority of respondents were Pediatricians, followed by Family Medicine Physicians.

Figure 1. Survey Respondents, by Profession



^aParticipants who answered “Other” were 2 Psychiatric Nurse Practitioners, 1 Clinical Social Worker, 1 Population Health Nurse, 1 Quality Coordinator, and 1 Critical Care Nurse.

Respondents identified the county and practice type of their primary work site, as shown in Figures 2 and 3. Surveys were collected from professionals working in all ten counties, primarily in hospital-affiliated clinics.

Figure 2. Survey Respondents, by Practice Type of Primary Work Site

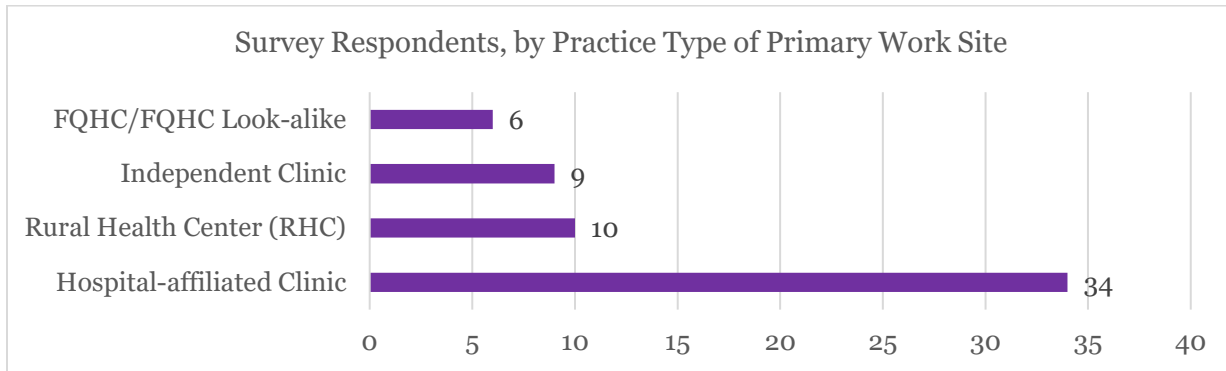
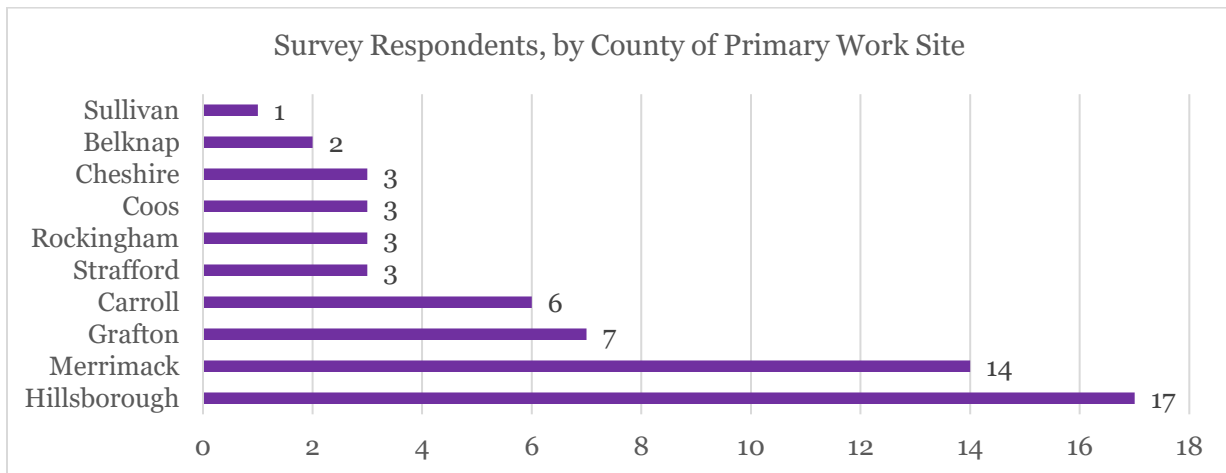


Figure 3. Survey Respondents, by County of Primary Work Site



Semi-structured Interviews

SSIs targeted two groups: people who work in a NH primary care setting that cares for children and adolescents and insurance payers that cover NH children and adolescents. Sampling resulted in a total of 13 SSIs: seven primary care practices, five insurance payers, and one psychiatric provider that consults across several primary care sites.

Claims Data

Data were analyzed from the New Hampshire Comprehensive Health Care Information System, NH's All-Payer Claims Database, and NH DHHS Enterprise Business Intelligence. Criteria for the analytic data were NH residents of less than 18 years of age and with at least nine months of enrollment, as determined by the most recent enrollment record in the analytic period.

Pediatric healthcare claims were analyzed to understand the extent to which BHI is evident through claims data. Analysis was focused on the following questions:

- 1) Payer mix: Which payers cover the majority of NH children? How does this compare with the payer mix of NH children with indication of mental health conditions?

- 2) Prescribing: What role does primary care play in prescribing for pediatric mental health conditions in NH?
- 3) BHI Services: Where, how, and by whom are BHI services being provided to NH children?

This report includes a limited summary of the analysis that was performed; a comprehensive report is available here: <https://scholars.unh.edu/ihpp/164/>.

Study Outcomes

A number of common themes related to youth behavioral health emerged from the three study methods, including the prevalence of youth behavioral health conditions, the role of primary care, and the potential for teleconsultations to help expand primary care capacity.

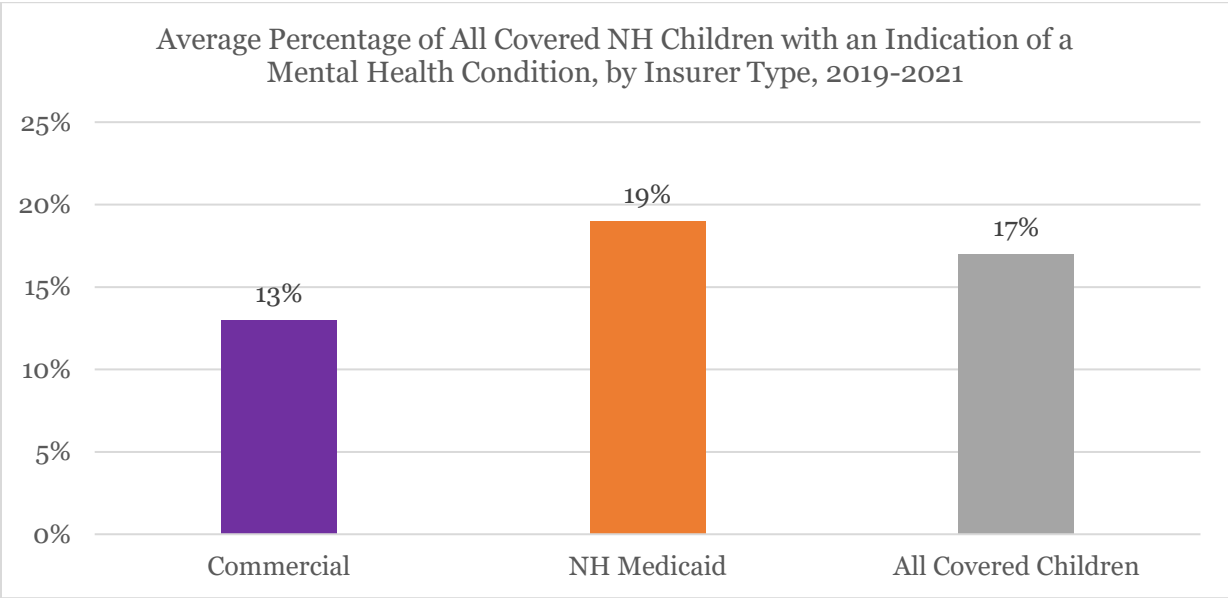
Prevalence of Youth Behavioral Health Conditions in NH

It is difficult to determine the true prevalence of youth behavioral health conditions in NH because analysis is limited to documented data. This impacts stakeholders' ability to understand the existing need, determine who is responsible for identifying solutions, and develop strategies to address it.

Between 2019 and 2021, 17% of covered NH youth had an indication of a mental health condition in their health care claims.

Over this period, 13% of commercially insured youth had such an indication, compared with 19% of Medicaid insured youth (see Figure 4).

Figure 4. Average Percentage of All Covered^a NH Children with an Indication of a Mental Health Condition^b, by Insurer Type, 2019-2021



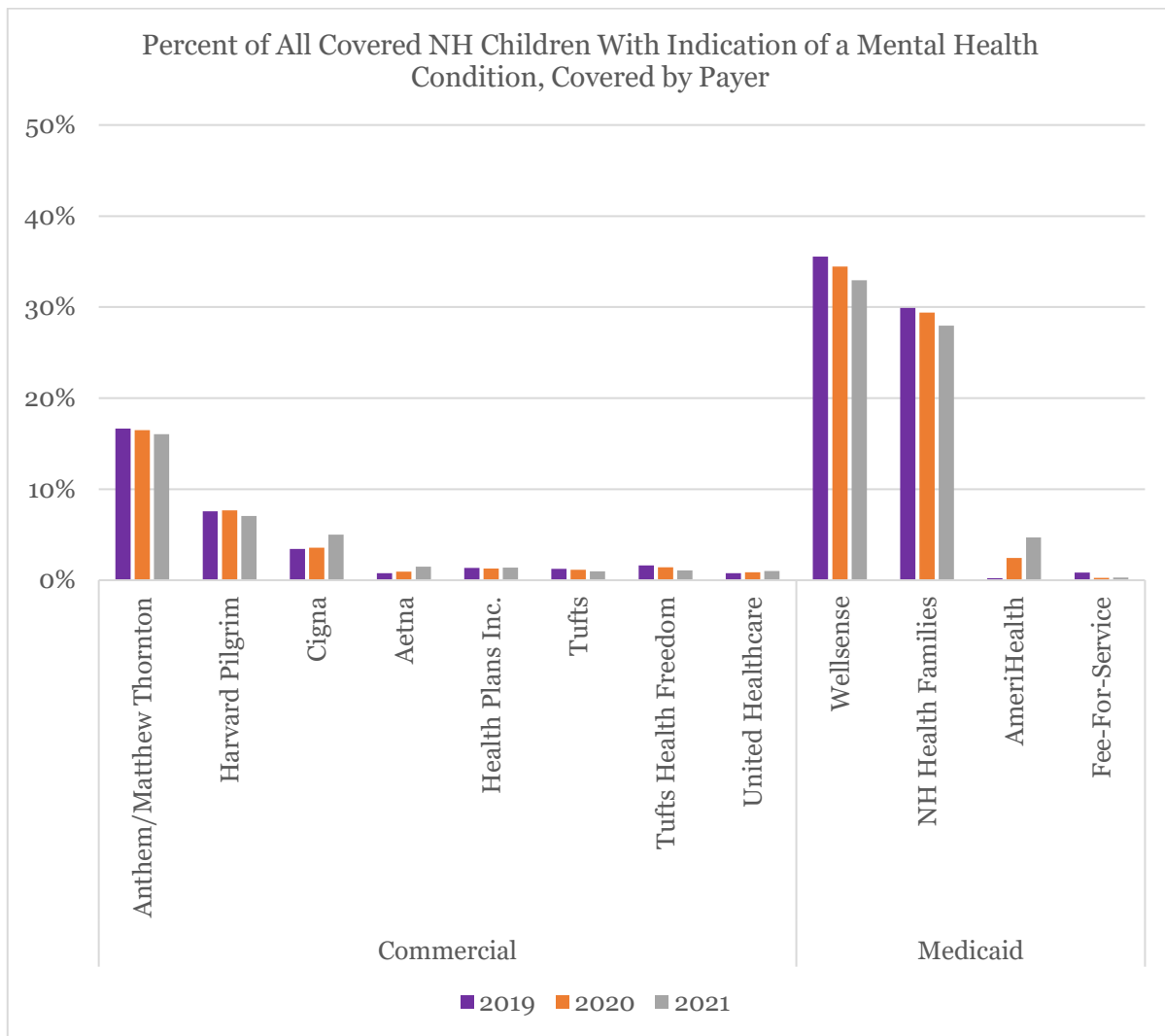
^aChildren with at least nine months continuous enrollment in NH Medicaid or a commercial insurance plan. Payer was assigned based on the member's most recent enrollment record in the analytic plan.

^bIndication of a mental health condition was satisfied by at least two medical claims with a diagnosis code for a mental health condition. The mental health diagnosis code was not required to be the primary diagnosis on the claim. See comprehensive report <https://scholars.unh.edu/ihpp/164/> for the list of included diagnosis codes.

Four medical insurance providers [payers] are responsible for the healthcare coverage of the majority of NH youth with indication of a mental health condition.

Claims Analysis: Pediatric claims were analyzed by payer and insurer type in order to understand which payers cover the majority of NH children with mental health conditions. As of 2021, WellSense insures the most NH children (33%), followed by NH Healthy Families (28%), Anthem/Matthew Thornton (16%), and Harvard Pilgrim (7%), as shown in Figure 5. This indicates that these four payers are top stakeholders in addressing pediatric behavioral health care in NH.

Figure 5. Percent of All Covered^a NH Children with an Indication of a Mental Health Condition^b, Covered by Payer, 2019-2021



^{a,b}See Figure 4


Role of Primary Care in Treating Youth Behavioral Health

Limited access to traditional behavioral health services has necessitated redefining the scope of primary care to include some behavioral health concerns. However, only one in three US pediatricians feel that they have sufficient training to diagnose and treat mental disorders.⁷ To understand the state of behavioral health in primary care in NH, it is critical to explore the attitudes and perceptions of payers and providers towards the role of PCPs in mental health.

Both payers and PCPs see the diagnosis and treatment of mild to moderate depression, anxiety, and ADHD as within the scope of primary care.

Survey: Over 95% of respondents identified the diagnosis of low mood (depression), anxiety, and ADHD as within the scope of primary care. Similarly, when asked which pediatric behavioral health conditions can be treated in primary care, over 93% of respondents again cited low mood (depression), anxiety, and ADHD. More than half of respondents named oppositional behaviors (63%) and trauma (54%) as diagnosable in primary care, though fewer felt it was in their scope to treat these conditions (42% and 31%, respectively). 95% of providers surveyed felt that mild to moderate behavioral health conditions can be appropriately diagnosed and treated in a primary care setting. These responses show that though many providers feel it is within their scope to diagnose behavioral health conditions, treating them may require a larger treatment management team.

Interviews: Interviews yielded the same top conditions for diagnosis and treatment in primary care. All eight providers interviewed, as well as all but one payer, identified anxiety, depression, and ADHD as appropriate for treatment and management in a primary care setting. Interviewees were also asked what complexity of behavioral health conditions fell within a primary care scope. Payers and providers agreed that mild to moderate conditions are appropriate, with two out of seven providers mentioning that they felt it was dependent on prior response to treatment and provider comfort and experience level. Interviewees acknowledged that many practices are currently managing conditions beyond that defined scope.

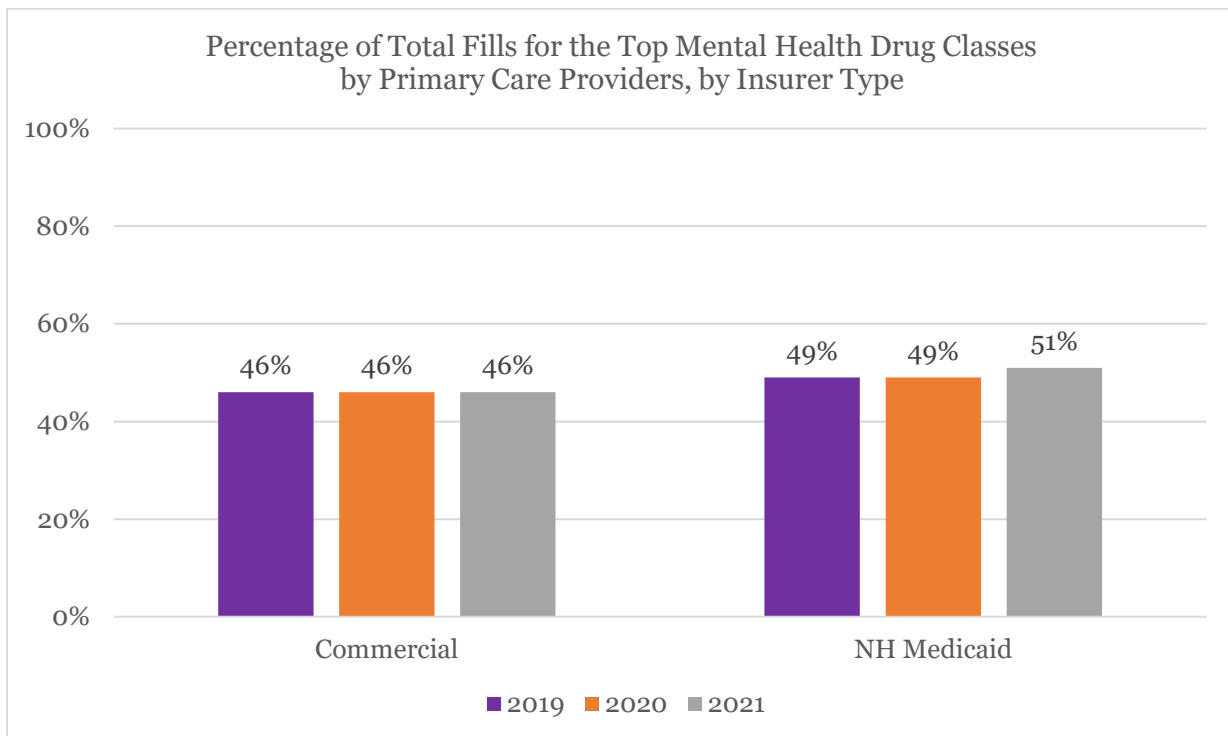


“If you ask for the last two years, every level has been within the scope of our practice because it has had to be unfortunately...There’s nowhere to send them...So we end up having very severely affected kids in our primary care practice” [Provider].

PCPs prescribe about half of the total mental health prescriptions for NH youth.

Claims Analysis: One way to understand the current state of pediatric behavioral health in primary care is how much PCPs are prescribing for mental health conditions. Pharmacy claims were analyzed to determine which providers (by taxonomy) were prescribing the most common mental health drug classes to NH children and teens, as well as whether this varied by insurer (Commercial vs NH Medicaid). Providers were categorized as primary care or non-primary care for this analysis. PCPs prescribed an average of 49% of total fills during the three-year period with some variation by insurer type: 50% of fills for NH Medicaid compared to 46% of fills for commercially insured youth (see Figure 6).

Figure 6. Percentage of Total Fills for Top Mental Health Drug Classes for NH Children by PCPs, by Insurer Type, 2019-2021



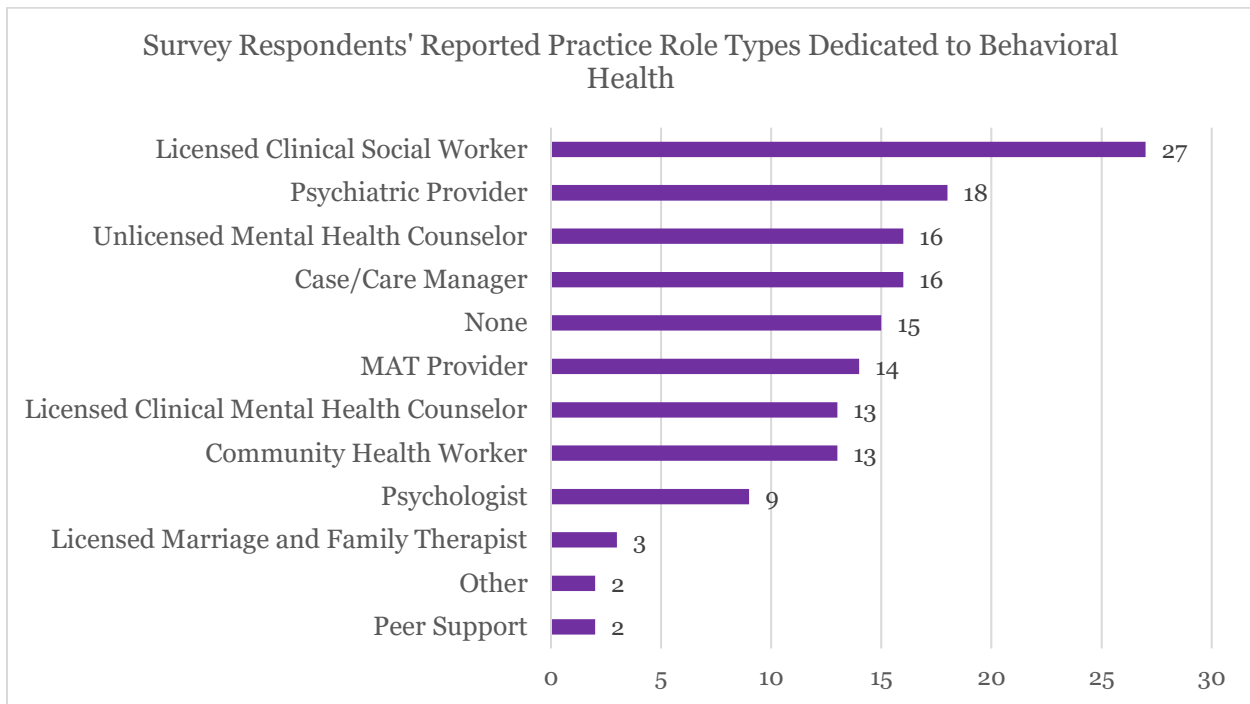
Behavioral Health Services Provided and Billed by Primary Care

The provision of behavioral health services in primary care depends heavily on the staff and role types available to a practice as well as the practice’s billing ability. The research team used self-reporting to examine which practices and regions were providing behavioral health services. They compared these self-reports to the health care claims data to assess the extent to which practices are successfully coding, billing, and getting reimbursed for these services.

Most practices have at least one role dedicated to supporting behavioral health, but the number and type of roles vary widely.

Survey: Respondents were asked to indicate which staff/role types are dedicated to supporting behavioral health at their practice. The most common staff type reported was a Licensed Clinical Social Worker (n=27) followed by a psychiatric provider (n=18), care manager (n=16), and unlicensed mental health counselor (n=16), as shown in Figure 7. 25% of respondents reported that they had no dedicated staff for behavioral health.

Figure 7. Survey Respondents’ Reported Practice Role Types Dedicated to Behavioral Health



Notes: Respondents (n=59) were asked to select all that apply. Respondents who selected “Other” identified a shared pediatric RN care coordinator and a psychiatric nurse practitioner. It should be noted that “Psychiatric Provider” is inclusive of psychiatric nurse practitioners, bringing the number of respondents with that staff type to 19.

Interviews: Of the eight providers that were interviewed, four have access in their practice to a psychiatric provider (MD, DO, PA, APRN) for consultation and for their patients to see. One of the providers has access to a BH clinician, two providers have access to a licensed clinical social worker and two have access to community health workers. One provider shared that having in-house behavioral health practitioners is more comfortable for patients, helps increase follow-through, and streamlines the process for patients.

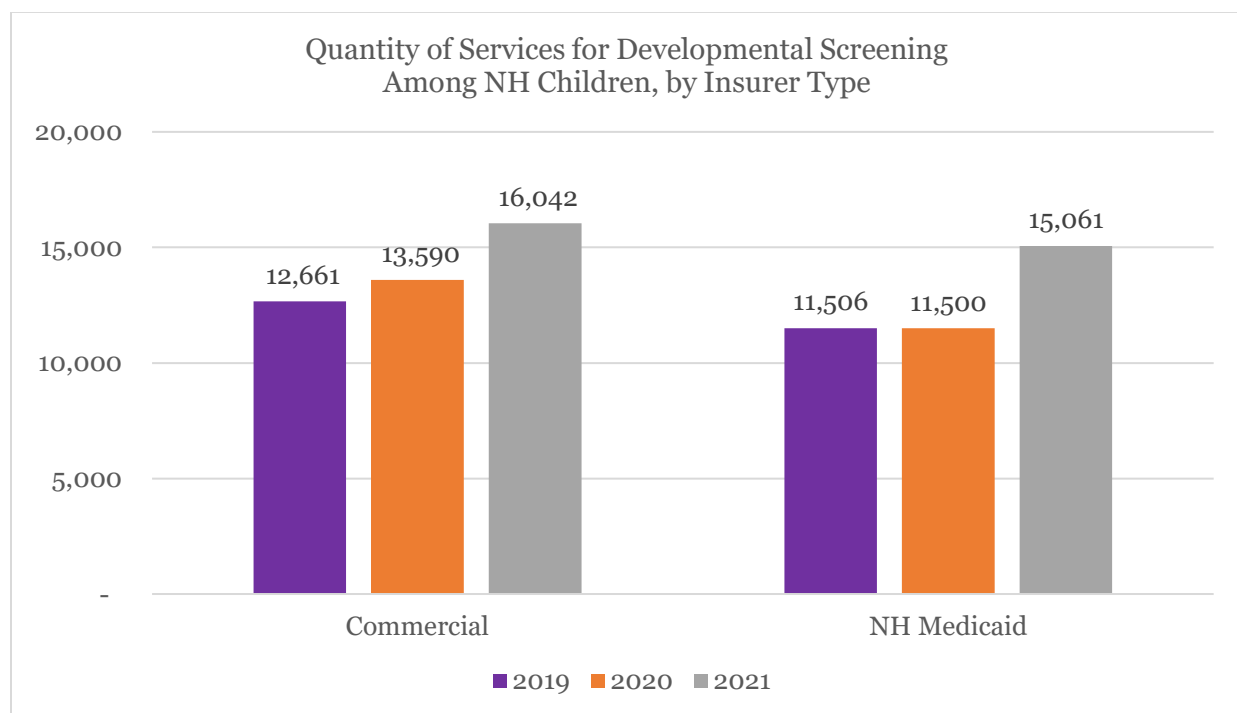
PCPs self-report a practice of universal screening, though evidence of claims is limited to developmental screening.

Surveys: Of those who reported that their practice billed any BHI service, 96% said that they screen (see Figure 9). When only one activity was identified as being billed, it was always “screening using evidence-based tools”.

Interviews: Interviewers asked about current practices for the identification of behavioral health conditions in primary care. Of the eight providers interviewed, seven perform universal screening on patients 12 and older as a preventative practice; however, it is not clear what conditions they are screening for. One provider stated, “as part of our well-child forms, we have embedded the age recommended screenings” [Provider]. Interviewee comments show an awareness that trauma is a contributing factor to behavioral health problems in pediatrics. One provider shared that “I think right now, trauma screening for us is as normal as you take a blood pressure because we just do it” [Provider]. Four of the interviewed practices use a registry to track and manage screening data.

Claims Analysis: Medical claims were analyzed to determine the use of specific integrated care billing codes associated with screening: Screening, Brief Intervention, and Referral to Treatment (SBIRT); Developmental Screening; and Collaborative Care. While Collaborative Care refers to a service broader than screening, it is included in this analysis as screening is a requirement for billing the codes. Analysis shows low utilization of Collaborative Care and SBIRT codes over the three-year period (27 claims and 32 claims, respectively) compared to Development Screening (see Figure 8).

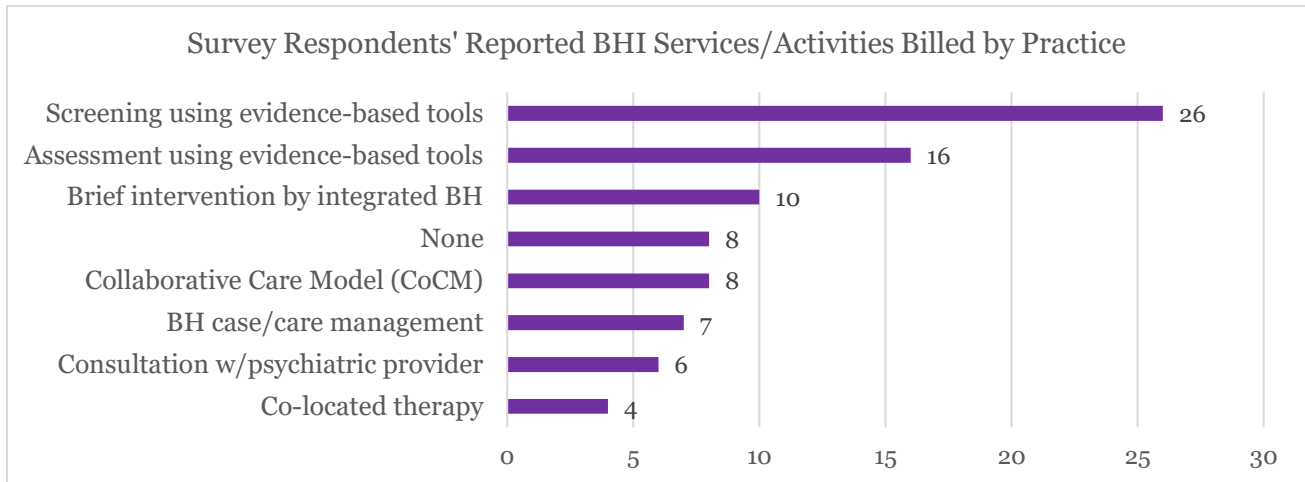
Figure 8. Quantity of Services for Developmental Screening Among NH Children, by Insurer Type, 2019-2021



Overall, utilization and billing of integrated behavioral health care services among NH youth is low.

Surveys: Survey respondents were asked about which BHI activities they were currently billing for. Screening and assessment were the most frequent responses, as shown in Figure 9. Nearly a quarter of respondents (23%) reported that no BHI services are being billed in their practice.

Figure 9. Survey Respondents’ Reported BHI Services/Activities Billed by Practice



Notes: Skip logic displayed this question to respondents who identified being knowledgeable about their practice’s billing practices (n=35). Survey respondents were asked to select all that apply.

Interviews: Provider interviewees were asked about what, if any, BHI services they are currently providing and billing for. Of those that were familiar with billing, the only billed services in common were universal screenings, using tools like the PHQ, GAD, and Vanderbilt screenings. Payers were asked whether they are paying or reimbursing for any integrated care-related services. Of the six interviewed, two answered yes, while one payer specified that they reimburse only for those codes billed by a behavioral health provider.

Claims Analysis: Claims data analysis by region, insurer, and payer helped provide a better understanding of the current BHI code utilization among NH children and adolescents. Analysis included codes that can only be used for BHI and excluded those that can be used for other purposes as well, such as psychotherapy or interprofessional consultation. As shown in Table 1, results show overall low use of BHI codes, with the exception of developmental screening (see Figure 8). Use of Health Behavior Assessment and Intervention codes increased during the three-year period, as did use of Collaborative Care codes.

Table 1. Integrated Care Codes Utilization and Volume (Quantity of Services) Among NH Children, 2019-2021

Integrated Care Code Category	Quantity of Services		
	2019	2020	2021
Collaborative Care Model	0	0	27
Developmental Screening	24,167	25,090	31,103
General BHI	0	1	4
Health Behavior Assessment and Intervention	8	172	349
Office-Based SUD Treatment	0	0	0
SBIRT	21	6	5

Barriers to Providing Behavioral Health Treatment in Primary Care

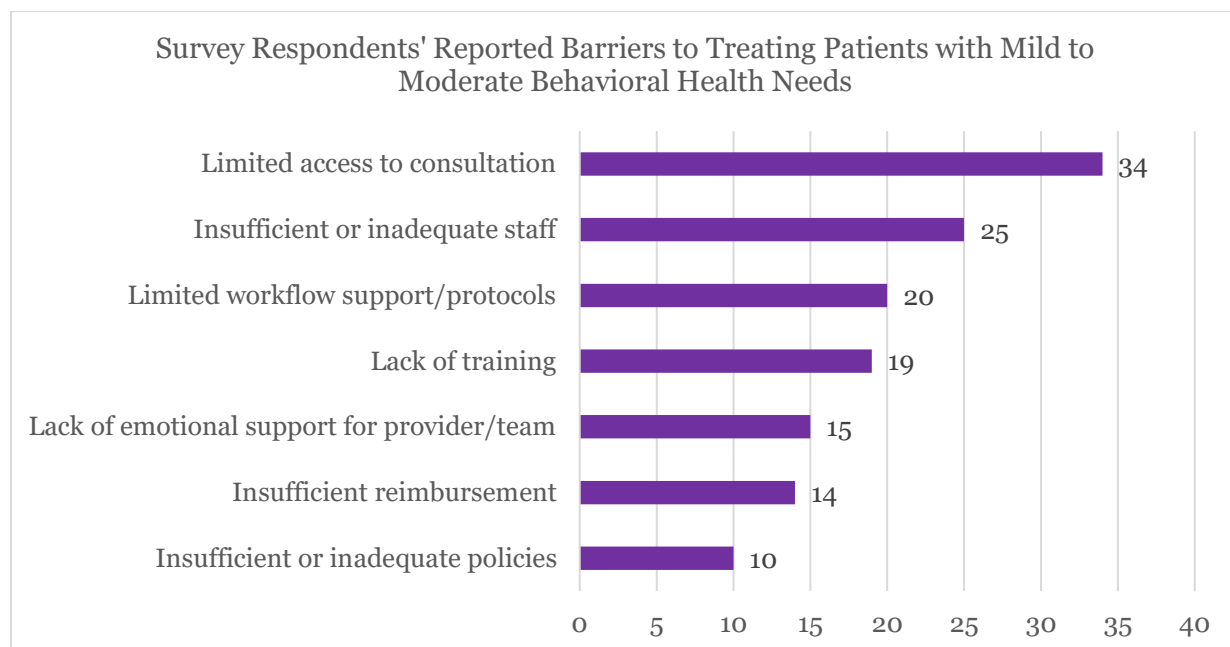
Despite the abundance of evidence in favor of BHI, uptake and utilization of BHI services and codes remains low. The research team sought to better understand the barriers to treating youth with behavioral health needs.

Primary care faces numerous barriers to treating patients with mild to moderate behavioral health needs.

Surveys: The top barriers to treating patients with mild to moderate behavioral health needs as identified by respondents were limited access to consultation, staffing issues, limited support for workflows and protocols, and a lack of training, as shown in Figure 10.

Interviews: Five out of eight providers cited a lack of referral partners as a barrier, with existing resources rendered unavailable by long wait times and lack of accessibility. As noted by an interviewee, “We can build in some supports within the system, but there’s a lack of resources outside” [Provider]. Desired resources include counseling, child psychiatry, parent and family services, and better collaboration with school systems. Additionally, five out of eight providers cited a lack of time to appropriately treat these issues.

Figure 10. Survey Respondents’ Reported Barriers to Treating Patients with Mild to Moderate Behavioral Health Needs



Notes: Respondents (n=59) were asked to select all that apply.

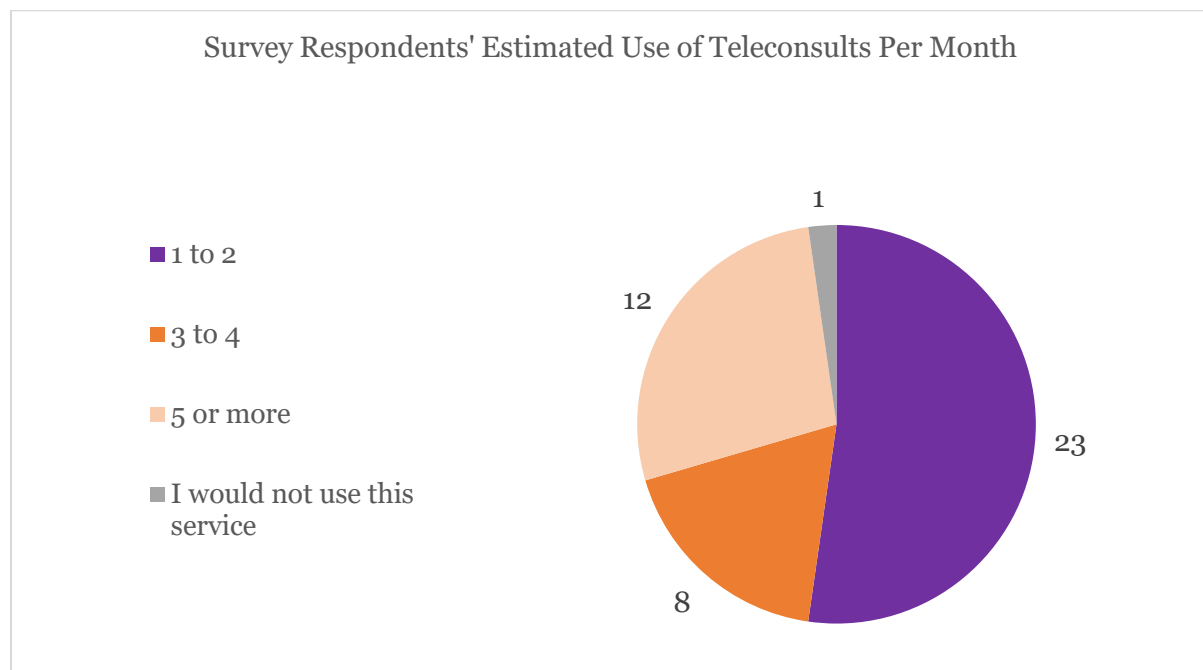
Role of Teleconsultation in Expanding Primary Care Capacity

Provider-to-provider teleconsultation with a CAP is one strategy to expand the capacity of primary care to address the needs of youth with behavioral health conditions. Teleconsults have been available to participating pediatric PCPs through NH MCAP since 2019 but uptake has been low. Researchers sought to understand how teleconsults might be structured to be of value to primary care professionals. An in-depth exploration of the evidence for and feasibility of this strategy is provided in the feasibility study.²

Most PCPs think they would benefit from and utilize a provider-to-provider teleconsult service to care for pediatric behavioral health.

Surveys: The majority of providers surveyed shared that they would use a teleconsult service 1-2 times a month, as shown in Figure 11.

Figure 11. Survey Respondents Estimated Use of Teleconsults Per Month



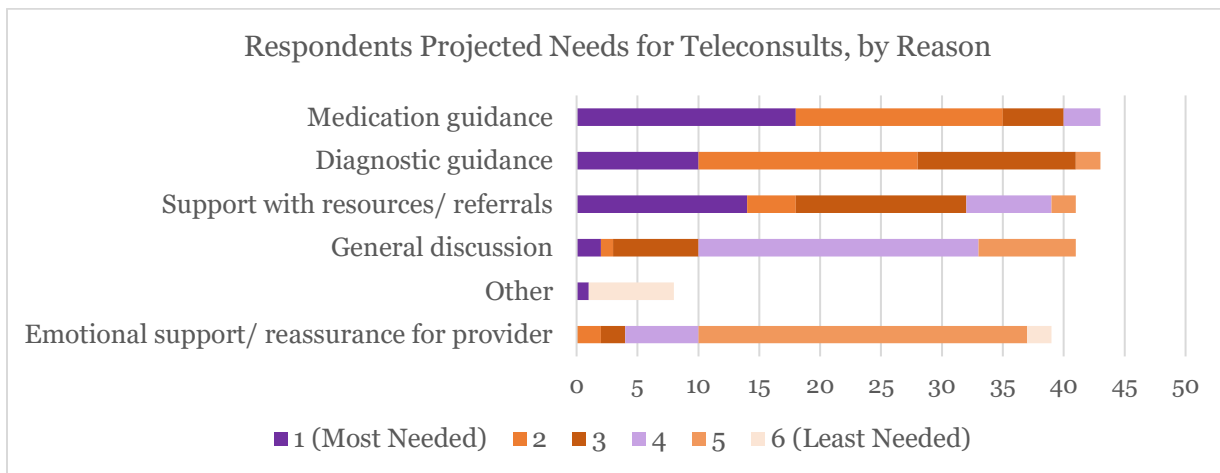
Notes: Skip logic displayed this question to respondents who identified as a PCP (n=44). Full question states “If you had access to external provider-to-provider consultation for pediatric patients with behavioral health needs, how many times per month would you use it?”

Interviews: The unanimous response among interviewees was that providers would use the access line five times or less per month. One provider stated that the line would be helpful “especially for newer providers,” while another said, “I think the longer you’ve been doing it [practicing], the less you actually need that.” [Providers]. Half of the payers interviewed said they would be in support of a child psychiatric access line.

Medication guidance and diagnostic guidance were the most commonly cited reasons why a PCP might use teleconsultation.

Surveys: Respondents were asked to rank the type of support they would need from a teleconsult from one (most needed) to six (least needed). As shown in Figure 12, medication guidance, diagnostic guidance, and support with resources/referrals were ranked in the top three by most respondents.

Figure 12. Survey Respondents’ Projected Needs for Teleconsults, by Reason

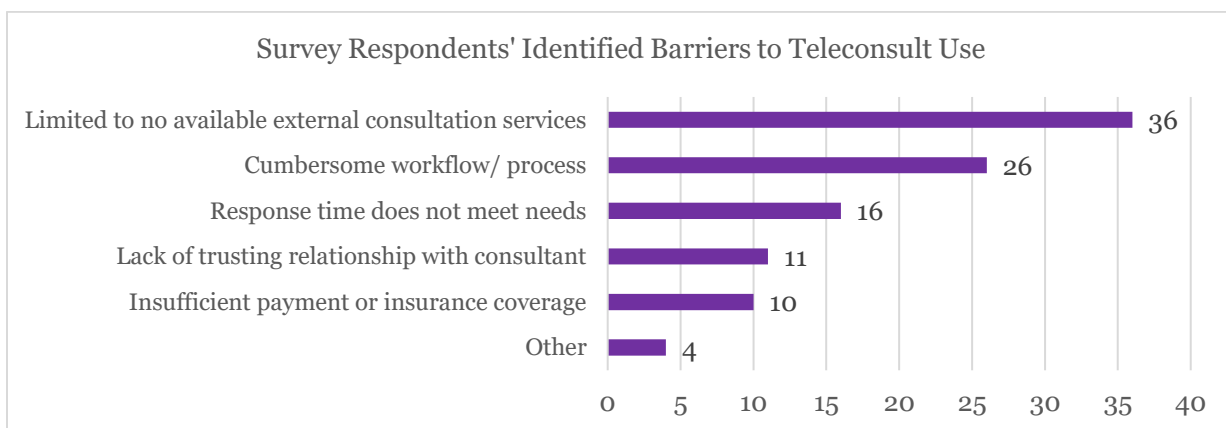


Interviews: Providers shared that consultation would be helpful for diagnostic and medication guidance and for cases that are worsening or not responding to multiple forms of treatment/medication.

The primary barrier to use of provider-to-provider teleconsultation is lack of access to, or awareness of, such a service.

Survey: Respondents who selected “other” identified lack of time to make teleconsult request and the consultant not having the right expertise for the questions (see Figure 13).

Figure 13. Survey Respondents’ Identified Barriers to Teleconsult Use

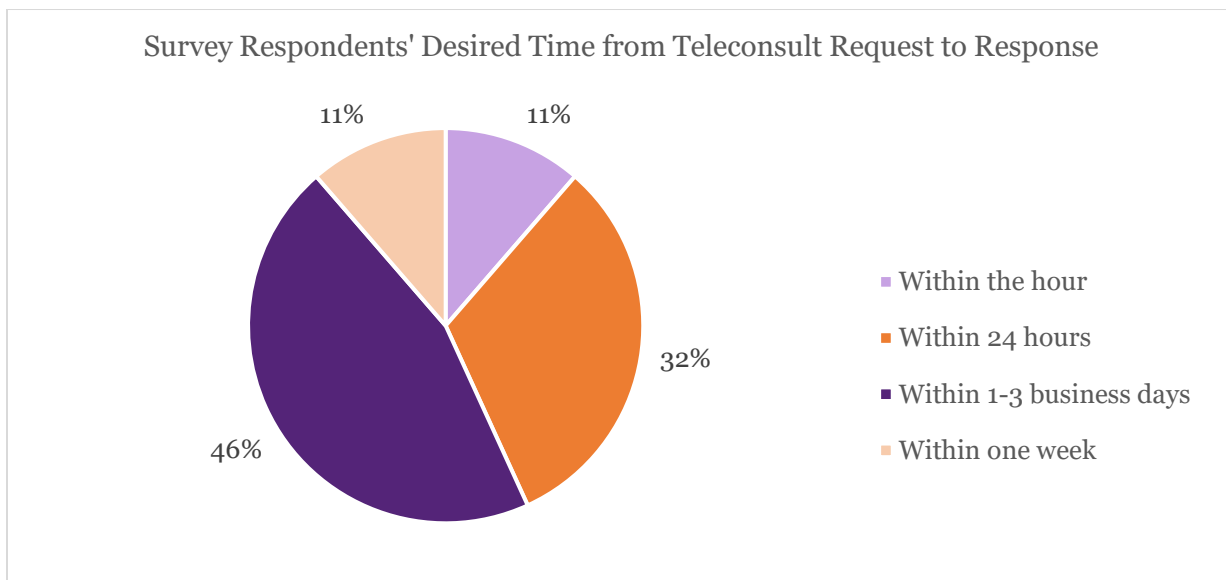


Interviews: The majority of providers mentioned the consultant’s response time as the biggest barrier to teleconsult use. Other barriers mentioned were issues with contact methods and the existing relationship with the consulting provider.

The preferred teleconsult modality for PCPs is a live phone call that takes place within 1-3 business days of the request.

Surveys: Over two thirds of respondents (68%) prefer a live phone call to an e-consult. Most providers surveyed do not need an immediate response to a teleconsult request for it to be helpful; between one to three business days (45%) and within 24 hours (32%) were the most selected responses (see Figure 14).

Figure 14. Survey Respondents’ Desired Time from Teleconsult Request to Response



Notes: Skip logic displayed this question to respondents who identified as a PCP (n=44).

Interviews: When asked about preferred consult method, most providers identified phone or video call as their preferred consult modality, with two preferring e-consults. One provider who preferred phone call had used e-consults before and reflected that it was difficult because the external consultant did not have access to their electronic health record (EHR). When asked about appropriate response time, all but one provider interviewed felt that 24-48 hours would be an appropriate response time; providers unanimously agreed that a few days to a week would be the maximum turnaround period. One of the providers interviewed felt that a response would be needed in less than 24 hours in order to be helpful.

Discussion

Limitations

The sample size of the survey and semi-structured interviews was too small to be representative of the state at large. This impacted researchers' ability to analyze responses by characteristics such as county or provider type. In addition, several interviewees and survey respondents were from a single health system. The study also did not collect respondents' personal demographics such as age, years in practice, or racial and ethnic data. It is unclear to what extent the sample reflects the full diversity of the state or if these characteristics would impact responses. Lastly, respondents and interviewees were asked to respond on behalf of their practices. However, study methods did not account for variation in knowledge of practices processes and procedures or for differing thoughts and opinions of team members working in the same practice.

The most complete available set of claims data was limited to the calendar year 2021 and earlier. Additionally, the percentage of NH youth with an indication of mental health conditions likely underestimates the true prevalence. Claims analysis relies on the presence of medical claims data, meaning if a child did not visit a doctor during the analyzed period—and receive a documented diagnosis—they would not be included in this count. Similarly, utilization data relies on billing and coding of a service. Analysis of pharmaceutical data is limited to prescription fills, meaning that the patient did not necessarily take the medication as prescribed. Analysis by race and ethnicity was impossible because these fields were unavailable or unreliable in claims data.

Recommendations for Future Study

While this study helps to clarify the current state of pediatric behavioral health in primary care, it also suggests a need for future study. Researchers noted some barriers to billing for BHI, but several interviewees did not know the specifics around billing practices; the research team is interested in better understanding the facilitators and barriers to effective billing and reimbursement for BHI services.

Several interviewees and respondents identified wanting a response to teleconsult request within one hour. Future study could clarify whether this is a result of provider workflow or case acuity, as teleconsult access programs are not generally intended to serve as crisis services. Future study is recommended to understand whether this is a function of provider workflow or case acuity, as teleconsult access programs are generally not intended to serve as crisis services. With respect to preferred teleconsult modality, the research team is interested in learning about how differences in the electronic health record might impact provider choice.

All respondents and interviewees identified barriers to treating pediatric patients with mild to moderate behavioral health needs. Strategies that mitigate these barriers merit further exploration. Additionally, research revealed a range of staff and role types available across various practices to support behavioral health needs. Future study is recommended to identify and understand which of these positions have the most significant impact on factors like access, outcomes, patient experience, cost, and provider satisfaction.

Closing Thoughts

This assessment provides a clear summary of the current state of BHI in pediatric primary care and can serve as a starting point for stakeholders to coordinate effective strategies to move forward. A small concentration of NH payers cover the majority of youth with an indication of a mental health condition, presenting a unique opportunity to mitigate the barriers PCPs are experiencing. PCPs play a key role in improving immediate access to behavioral health care; this issue cannot be resolved solely by expanding the behavioral health workforce. Pediatric PCPs are well-positioned to identify and treat mild to moderate behavioral health needs and are already prescribing almost half of all mental health medications, but they need more support. Under the BHI umbrella, there are reimbursable, evidence-based treatment models that could address many issues; yet this assessment shows how they are challenging to implement and severely underutilized in NH. With effective and adequate support, primary care can play an even bigger role in providing and promoting access to behavioral health care for NH children and teens.

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Appendix A:

Study Methods Detail

This study was approved by the institutional review board (IRB) at the University of New Hampshire.

Survey: The survey targeted people who work in NH primary care settings that care for children and adolescents. The team sent an email introducing the project with a link to the online Qualtrics survey to an initial convenience sample of primary care professionals, health care leaders, and professional associations that have an existing relationship with the research institute. From there, snowball sampling was used to maximize sample size. Survey responses were included if the respondent completed the consent form and met eligibility criteria.

The survey was comprised of 27 questions total (see Appendix B); however, skip logic was utilized to reduce the questions asked of each respondent. Respondents who indicated that they are primary care professionals were asked specific questions about the potential use and usefulness of provider-to-provider teleconsultation. Respondents who indicated that they are familiar with the Collaborative Care Model (CoCM) were asked if they feel it would be beneficial to their practice. Finally, respondents who were familiar with the billing process were asked about specific services their practice bills for and any barriers they experience in doing so.

Semi-Structured Interviews: Purposive sampling was used with primary care practices to increase distribution of county and practice type and with insurance payers to recruit both NH Medicaid Managed Care Organizations (MCOs) and commercial payers. The team sent an email introducing the project and linking online consent and interview scheduling tools. Participants were invited to interview as either individuals or a small group. A total of 15 SSIs occurred from May through August 2023 via Zoom: 7 primary care practices, 5 insurance payers, and 1 psychiatric provider. Two researchers conducted the interviews, following one of two interview guides (depending on participant type) with open-ended questions developed in line with study aims (see Appendix C and D). Each interview was audio recorded and transcribed via Zoom, with field notes taken by a trained researcher. Two independent researchers identified themes and concepts using transcripts notes, and audio recordings.

Appendix B:

Survey Tool

Thank you for your willingness to share your thoughts with us on the current state of pediatric behavioral health in primary care in NH. Insights gathered from responses to the survey will help to identify gaps and opportunities to inform future initiatives.

1. This survey is intended for clinical and administrative professionals who work in a primary care setting in NH that cares for children. Do you meet these criteria?

- a. Yes
- b. No

[If no, survey ends with message: "Thank you for your interest in this survey. Based on your response to the previous question, you do not meet criteria for inclusion in this research."]

2. Name: _____

3. Profession:

- a. Family Medicine Physician (MD/DO)
- b. Family Nurse Practitioner
- c. MD/DO Specialist (please specify): _____
- d. Medical Assistant
- e. Nurse
- f. Pediatrician (MD/DO)
- g. Pediatric Nurse Practitioner
- h. Physician Assistant
- i. Practice Manager/Administrator
- j. Other: _____

If you work in more than one primary care practice setting, please answer the following questions based on the primary care practice in which you work most:

4. What is your practice setting? *Select all that apply.*

- a. FQHC or FQHC look-alike
- b. Hospital-affiliated clinic
- c. Independent clinic
- d. Rural health center

5. In which county is your practice located?

- a. Belknap
- b. Carroll
- c. Cheshire
- d. Coos
- e. Grafton
- f. Hillsborough
- g. Merrimack
- h. Rockingham
- i. Strafford
- j. Sullivan

6. Practice name: _____

7. Which pediatric behavioral health conditions do you consider to be within the scope of primary care practice to diagnose? *Select all that apply.*

- a. Low Mood (depression)
- b. Anxiety

- c. ADHD
 - d. Oppositional behaviors
 - e. Trauma
 - f. Other: _____
8. Which pediatric behavioral health conditions do you consider to be within the scope of primary care practice to treat? *Select all that apply.*
- a. Low Mood (depression)
 - b. Anxiety
 - c. ADHD
 - d. Oppositional behaviors
 - e. Trauma
 - f. Other: _____

9. What level of pediatric behavioral health conditions do you consider to be within the scope of primary care practice?

Mild						Moderate					Severe
0	1	2	3	4	5	6	7	8	9	10	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

10. What activities/services is your practice currently providing to support pediatric patients with behavioral health needs? *Select all that apply.*
- a. Universal screening using evidence-based tools
 - b. Assessment after positive screens using evidence-based tools
 - c. Treatment monitoring using evidence-based tools
 - d. Consultation with psychiatric providers
 - e. Co-located therapy
 - f. Brief intervention by integrated behavioral health providers
 - g. Behavioral health care/case management
 - h. Use of patient registry to monitor patients with behavioral health symptoms
 - i. Collaborative Care Model
 - j. Other: _____
11. Does your practice have staff dedicated to providing behavioral health support? *Select all that apply.*
- a. Psychologist (PsyD, PhD)
 - b. Psychiatric Provider (MD, DO, APRN, PA)
 - c. MAT Provider (MD, DO, APRN, PA)
 - d. Case/care manager
 - e. Community Health Workers (CHW)
 - f. Unlicensed mental health counselor (MSW, MFT, MS)
 - g. Licensed Clinical Social Worker (LCSW)
 - h. Licensed Marriage and Family Therapist (LMFT)
 - i. Licensed Clinical Mental Health Counselor (LCMHC)
 - j. Peer Support (PSS, CRSW)
 - k. None of the above
 - l. Other: _____
12. Do you experience barriers to managing pediatric patients with mild to moderate behavioral health symptoms? *Select all that apply.*
- a. Lack of training
 - b. Insufficient or inadequate policies
 - c. Limited workflow support/protocols
 - d. Limited access to consultation
 - e. Insufficient or inadequate staff
 - f. Lack of emotional support for provider/team
 - g. Insufficient reimbursement

- h. None of the above
 - i. Other: _____
13. Are you a primary care provider?
- a. Yes
 - b. No [*if no, skips to question 19*]
14. When you need additional support treating a pediatric patient with behavioral health needs, what are the primary reasons? (Rank the options below from 1-6 with 1 being your primary reason; write the number in the box next to each option)
- Diagnostic guidance
 - Medication guidance
 - Support with resources/referrals
 - General discussion
 - Emotional support/reassurance for provider
 - Other: _____
15. If you had access to external provider-to-provider consultation for pediatric patients with behavioral health needs, how many times per month would you use it?
- a. 1-2
 - b. 3-4
 - c. 5 or more
 - d. I would not use this service
16. How quickly would you require a response from an external provider to provider consultant for it to be helpful to you?
- a. Within the hour
 - b. Within 24 hours
 - c. Within 1-3 business days
 - d. Within one week
17. What are the top 3 barriers to using external provider to provider consultation? (Select 3)
- a. Limited to no available external consultation resources
 - b. Response time does not meet needs
 - c. Cumbersome workflow/process
 - d. Insufficient payment or insurance coverage
 - e. Lack of trusting relationship with consultant
 - f. Other: _____
18. What is your preferred modality for external provider to provider consultation
- a. E-consult
 - b. Live phone call
 - c. Live video call

NH MCAP utilizes the Extension for Community Health Outcomes (ECHO) model to provide training and teleconsultation to primary care teams in support of pediatric mental health.

19. What training topics would you like NH MCAP Project ECHO to cover?

20. Is there a day/time that you would be able to participate in future NH MCAP Project ECHO sessions?
- a. Days/times I could participate for 60 min: _____
 - b. Days/times I could participate for 90 min: _____
 - c. I do not have the ability to participate in NH MCAP Project ECHO
 - d. I would prefer a different training modality: _____
21. Are you familiar with the Collaborative Care Model (CoCM)?
- a. Yes
 - b. No [*if no, skips to question 23*]
22. Do you think the Collaborative Care Model (CoCM) could be beneficial to your practice?
- a. Yes: optional

- b. Maybe: *optional*
 - c. No: *optional*
23. Do you have knowledge of your practice's billing processes?
- a. Yes
 - b. No [*If no, skips to question 27*]
24. Are you billing for any of these activities or services? *Select all that apply.*
- a. Screening using evidence-based tools
 - b. Assessment using evidence-based tools
 - c. Consultation with psychiatric providers
 - d. Co-located therapy
 - e. Brief intervention by integrated behavioral health providers
 - f. Behavioral health care/case management
 - g. Collaborative Care Model (CoCM)
 - h. I don't know
25. What are the top 3 barriers to billing integrated codes? *Select 3.*
- a. Low reimbursement
 - b. Denials
 - c. Variation across payers
 - d. Technical challenges
 - e. Staffing challenges
 - f. Gaps in education/understanding
 - g. Don't know
 - h. Other: _____
26. Are you receiving payment for any of these activities or services via an alternative payment model?
- a. Yes: (*optional*)
 - b. No
 - c. Don't know
27. Please share anything else you'd like us to know about your thoughts, ideas, or experiences related to pediatric patients with behavioral health needs: (*optional*)

Appendix C:

Semi Structured Interview Protocol - Primary Care

Introduction & Overview of Project (5 minutes)

Verify that consents are on file for all participants. If a participant has not consented, they may either complete the consent electronically before the interview begins or choose not to participate.

****Begin recording****

“Thank you so much for taking the time to meet with us today and your willingness to share your thoughts on pediatric behavioral health in primary care in NH. As a reminder, we will be recording this interview to support transcription. My name is _____ and I work on the NH MCAP Project as a _____. I will be the interviewer today. This is my colleague _____ who will be taking notes. Please introduce yourselves for the recording including your credentials and your position at your organization.” **** Pause for introductions**** “Prior to this interview, you were each sent a link to the electronic consent form. We have verified that we have obtained consent from each participant in today’s interview. Our discussion today is focused on pediatric behavioral health in primary care in NH. Some of the topics we will be discussing are assessment and treatment of behavioral health conditions; policies, workflows, and team roles at your practice; gaps and opportunities in service delivery; and billing and reimbursement for integrated care services. We are interested in your ideas, comments, and suggestions. This gathering of information is to understand gaps and opportunities in NH to inform future initiatives.”

Scope Questions (5 min)

1. Which pediatric behavioral health conditions do you consider to be within the scope of primary care practice?
2. What level of pediatric behavioral health conditions do you consider to be within the scope of primary care practice?
3. Does your practice have staff dedicated to providing support for behavioral health needs? If so, what roles/professions/credentials?
4. What would you identify as the biggest barriers to managing pediatric patients with mild to moderate behavioral health symptoms?

Provider to Provider Consultation (7 min)

The next five questions ask about provider to provider consultation for pediatric patients with behavioral health needs with a specialist that works outside of the primary care practice. Consider each question with reference to primary care providers at this practice.

5. For what purposes would providers need consultation? Which of these reasons is most important?
6. How many times per month do you think providers would use this service?
7. Consider a typical pediatric behavioral health case. How quickly would a provider require a response from a consultant for it to be helpful?
8. What are the barriers to using or accessing this service?
9. What is the preferred modality for this service: e-consults, live phone call, or live video call? Why?
10. Are you familiar with the Collaborative Care Model?
 - a. *If yes*, What do you understand to be the benefits and barriers of implementing this model?

Workflows, Processes, & Protocols (7 min)

The next five questions will be focused on identifying standardized processes, protocols or guidelines around pediatric behavioral health that are in place at your practice.

11. Does your practice universally screen pediatric patients for behavioral health symptoms? If so, which tools? How is the team prompted to complete this screening?
12. Does your practice assess for pediatric behavioral health conditions after a positive screen? If so, for which conditions? Who conducts further assessment? How? Which tools are used?
13. Does your practice have protocols for pharmacological treatment of pediatric behavioral health symptoms? If so, for which conditions? How do providers reference these protocols?
14. Does your practice monitor response to treatment for behavioral health needs? If so, how?
15. Does your practice make pediatric behavioral health referrals? If so, for which symptoms/conditions/behaviors? Do you monitor follow-through? What challenges do you experience with referring and follow-through?

Payment & Reimbursement Questions (7 min)

Please answer the following questions on your organization's billing processes to the best of your ability.

16. Do you have knowledge of your organization's billing processes?
 - a. *If yes, continue. If no, go to Question 21*
17. The next few questions will ask about the activities and services that this practice is currently providing to support pediatric patients with behavioral health needs. Please respond yes or no:
 - a. Consultation with psychiatric providers
 - b. Co-located therapy
 - c. Brief intervention by integrated behavioral health providers
 - d. Behavioral health care/case management
 - e. Use of patient registry to monitor patients with behavioral health symptoms
 - f. Collaborative Care Model
18. Are you billing CPT codes for any integrated care activities or services? Are you receiving reimbursement? From which payers?
19. What are the barriers to billing integrated codes?
20. Are you receiving payment for any of these activities or services via an alternative payment model?
 - a. If yes, which activities and services? Which payers? How is this APM structured?
21. Is there anything else you'd like to share about your thoughts, ideas, or experiences related to supporting pediatric patients with behavioral health needs?

Appendix D:

Semi Structured Interview Protocol - Payer

Introduction & Overview of Project (5 minutes)

Verify that consents are on file for all participants. If a participant has not consented, they may either complete the consent electronically before the interview begins or choose not to participate.

****Begin recording****

“Thank you so much for taking the time to meet with us today and your willingness to share your thoughts on pediatric behavioral health in primary care in NH. As a reminder, we will be recording this interview to support transcription. My name is _____ and I work on the NH MCAP Project as a _____. I will be the interviewer today. This is my colleague _____ who will be taking notes. Please introduce yourselves for the recording including your credentials and your position at your organization.” **** Pause for introductions**** “Prior to this interview, you were each sent a link to the electronic consent form. We have verified that we have obtained consent from each participant in today’s interview. Our discussion today is focused on pediatric behavioral health in primary care in NH. Some of the topics we will be discussing are expectations for providers and practices regarding assessment and treatment of behavioral health conditions; gaps and opportunities in service delivery; and billing and reimbursement for integrated care services. We are interested in your ideas, comments, and suggestions. This gathering of information is to understand gaps and opportunities in NH to inform future initiatives.”

Scope Questions (3 min)

1. Which pediatric behavioral health conditions do you consider to be within the scope of primary care practice?
2. What level of pediatric behavioral health conditions do you consider to be within the scope of primary care practice?

Expectations for Providers/Practices (8 min)

“The next six questions ask about the expectations you have for providers and practices with regard to the care of pediatric patients with behavioral health needs.”

3. Are providers/practices expected to screen for pediatric behavioral health symptoms? If so, which symptoms and which tools?
 - a. If they have a positive screen, are providers/practices expected to provide further assessment? If so, which conditions and which tools?
4. Are providers/practices expected to have protocols for pharmacological treatment of pediatric behavioral health symptoms? If so, for which symptoms/conditions?
5. Are providers/practices expected to monitor response to treatment for behavioral health needs? If so, how?
6. Are providers/practices expected to refer out for specific pediatric behavioral health conditions, symptoms, or behaviors? If so, are they expected to monitor follow-through? How do you facilitate referrals in network?
7. How do you communicate or incentivize these expectations?

Payment & Reimbursement Questions (7 min)

8. Are you paying for any integrated care activities or services in support of pediatric behavioral health via an alternative payment model? If yes, how is the APM structured?
9. What have you heard might be barriers to billing integrated codes?

Opportunity Questions (7 min)

10. What strategies do you endorse to promote pediatric mental health care access in primary care?
11. Are you contributing to implementation of the Collaborative Care Model in other markets?
12. Would that be something you would support in NH? How would you support it?
13. Are you contributing to funding for a psychiatric access line in other markets?
14. Would that be something you would support in NH? How would you support it?