ISSUE BRIEF

Special Topics Issue Brief #8

Health Centers' Role in Addressing the Behavioral Health Needs of the Medically Underserved

September 2004

Prepared by

Michelle Proser
Research and Data Analyst
Department of Federal, State, and Public Affairs
National Association of Community Health Centers, Inc.
2001 L Street, NW, 2nd Floor
Washington, DC 20036
(202) 296-1960 ~ mproser@nachc.com

and

Lisa Cox
Assistant Director, Public Health Policy
Department of Federal, State, and Public Affairs
National Association of Community Health Centers, Inc.
2001 L Street, NW, 2nd Floor
Washington, DC 20036
(202) 296-0923 ~ lcox@nachc.com

This publication was supported by Grant/Cooperative Agreement Number U30CS00209 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

Special thanks to the following reviewers for their helpful feedback:

Michael Barr, Chief Medical Officer, Baltimore Medical System
Pat Forman, Program Manager, Mental Health,
San Francisco Community Clinic Consortium
Warren Hix, Executive Director, Sandhills Health Center
Paul Melinkovich, Director, Denver School-Based Health Centers, Denver Health

Special thanks are also extended to the following people for their extensive feedback, guidance in preparing this issue brief, and research and writing assistance:

Charles Brown, NACHC FSA Intern
Bradley Crotty, NACHC FSA Intern
Kathy McNamara, Assistant Director for Clinical Affairs, NACHC
Kirk Strosahl, Mountain View Consulting Group, Inc.

Executive Summary

Up to 28% of Americans have a diagnosable behavioral health condition, and few seek treatment. In the primary care setting, the majority of visits have a psychosocial basis. Health centers, as primary care providers to 15 million medically underserved individuals, are critically important sources of behavioral health services to millions of people with some of the highest unmet needs. This issue brief describes and documents health centers' role in meeting the behavioral health needs of low-income and at-risk populations, and discusses the importance of service integration and challenges related to funding for these services.

Major findings of this issue brief include:

- The very people and communities that make up the greatest proportion of health center patients – low-income families, minorities, the uninsured, rural residents – experience more unmet mental health needs and thus suffer a greater loss to their overall health. Health centers narrow or even eliminate disparities in behavioral health treatment and outcomes by removing common barriers to care and closely coordinating their behavioral health and primary care services.

- Nearly every health center provides mental health and substance abuse services onsite or through formal referral arrangements. When combined, the number of mental health and substance abuse related encounters grew faster than other major chronic conditions over the last four years. Mental health and substance abuse-related conditions together constitute the leading reason for a visit to a health center.

- Many health centers are engaged in the Bureau of Primary Health Care's Health Disparities Collaboratives to improve outcomes for patients with chronic conditions. At least 78 health centers are participating in a Collaborative focused on depression, and many more are participating in Collaboratives focusing on other chronic conditions and include a depression screening component. Health centers have seen improved screening rates, rates of follow-up care, and outcomes.

- Integrating behavioral health with primary care leads to improvements in the process of care, quality of life, health outcomes, and is cost-effective. Many health centers operate fully integrated models of care or are working to establish such a model.

- Reimbursement for the provision of behavioral health conditions at health centers can be extremely challenging. Health centers must seek resources to leverage HRSA Mental Health Expansion funding from a variety of sources, including the Medicaid and Medicare programs and the Substance Abuse and Mental Health Services Administration.

It is abundantly clear that behavioral health stands out as a compelling and immediate issue confronting the national health care system and health centers in particular. Controlling health care costs requires that behavioral health needs be adequately addressed. Health centers have already made impressive strides toward the culturally competent integration of behavioral health and primary care services to better address the needs of the diverse and growing population seen at health centers. However, significant challenges remain as health centers continue to expand their capacity to better meet the behavioral health care needs of their patients.

Introduction

In its July 2003 final report, President Bush's New Freedom Commission on Mental Health concluded that behavioral health services in the United States are fragmented, too many individuals have unmet needs, and "many barriers impede care for people with mental illness."[1] This conclusion has not been lost on America's Health Centers, who have long recognized that the nation's health care safety net must weave together primary care, mental health and substance abuse services in order to adequately serve uninsured and underserved individuals.

In 1997, the United States spent more than $1 trillion on health care in general, including $71 billion on mental illness alone,[2] thus, treating behavioral health conditions is critical in controlling the cost of health care. In any given year, up to 28% of Americans have a diagnosable mental health and addictive disorder, and of these only 29% sought treatment services[3] regardless of insurance status. Other research finds that only half of individuals with mental health and substance abuse conditions seek treatment.[4] Yet these statistics may not include the millions of primary care patients experiencing factors related to behavioral health disorders. In fact, nearly 70% of all primary care visits have a psychosocial basis.[5] Factors that drive psychosocial-related medical utilization include mental health and substance abuse disorders, stress, lack of coping skills and other psychological and social conditions.[6] Such factors commonly occur in frequent users of medical service,[7] and primary care patients with mild to severe levels of depression use between two and three times the amount of primary care than non-depressed patients.[8]

It has been well documented that the majority of Americans receiving treatment for behavioral health conditions receive it from a primary care physician.[9] Health centers, as primary care providers to 15 million medically underserved individuals, are critical sources of behavioral health services to those with the highest unmet needs. In fact, some health centers report as many as 70% of patients have a behavioral health disorder.[10] A recent Kaiser Commission on Medicaid and the Uninsured study found that uninsured health center patients –

---

[1] New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

[2] Rice, D. P. & Miller, L. S. (1996). The economic burden of schizophrenia: Conceptual and methodological issues and cost estimates. In M. Moscarelli, A. Rupp, & N. Sartorius (Eds.), *Schizophrenia* (pp. 321-334). Chichester, UK: Wiley.

[3] Regier D, et al. "The De Facto US Mental and Addictive Disorders Service System: Epidemiologic Catchment Area Prospective 1 Year Prevalence Rates of Disorders and Services." 1993 *Archives of General Psychiatry* 50(2):85-94.

[4] Narrow W, et al. "Use of Services By Persons with Mental and Addiction Disorders: Findings from the National Institute of Mental Health Epidemiologic Catchment Area Program." 1993 *Archives of General Psychiatry* 50(2):95-107.

[5] Fries J, Koop C, and Beadle C. "Reducing Health Care Costs by Reducing the Need and Demand for Medical Services." 1993 *New England Journal of Medicine* 329(5):321-325.

[6] Friedman R, et al. "Behavioral Medicine, Clinical Health Psychology and Cost Offset." November 1995 *Health Psychology* 14(6):509-18.

[7] Katon W, et al. "A Randomized Trial of Psychiatric Consultation with Distressed High Utilizers." 1992 *General Hospital Psychiatry* 14:86-98.

[8] Simon G. "Psychiatric Disorder and Functional Somatic Symptoms as Predictors or Health Care Use." 1992 P*sychiatric Medicine* 10:49-60.

[9] Quirk MP, et al. "A Look to the Past, Directions for the Future." Spring 2000 *Psychiatric* Quarterly 71(1):79-95. Narrow, et al, 1993.

[10] Based on email communication with Kirk Strosahl, Mountainview Consulting Group, Inc., August 26, 2004, and Brammer C. "Mid-West Clinicians' Network Behavioral Health Survey: A Study of Clinicians' Attitudes Regarding Behavioral Health Needs and Services in Community Health Centers." Mid-West Clinicians Network Research Team, Midwest Primary Care Association. May 2000.

many of them new patients after having recently lost insurance coverage – tended to experience serious physical as well as mental illness, and new uninsured patients tended to delay seeking care until their health problems were severe. Moreover, nearly every health center interviewed reported increased volumes of patients with mental illness and alcohol and other addiction disorders among all uninsured patients, often causing longer wait times for appointments. Many of these patients needed a level of intervention beyond their health centers' capacity.[11]

Clearly, behavioral health issues have an ever-expanding presence at health centers; indeed, mental health and substance abuse together constitute the leading reason for a visit to a health center, with health supervision of children under 12 a close second, and hypertension a close third. According to the 2003 Uniform Data System (UDS),[12] health centers reported over 2.1 million encounters for mental health conditions, and another 720,000 encounters for drug or alcohol dependence. While health centers have demonstrated significant commitment in addressing behavioral health issues, a number of key challenges will shape health centers' ability to treat the mental and emotional as well as the physical well being of their patients, such as access to adequate coverage for mental health care, the presence of an adequate mental health workforce at health centers, and the development of successful models for the provision of both behavioral and primary health care at health centers.

The National Association of Community Health Centers has followed developments in the area of behavioral health and is working to assist health centers to expand the provision of these services for the communities they serve. NACHC is interested in promoting the health center model as one effective approach to making behavioral health care affordable and available to low-income uninsured and underserved individuals across the lifecycle. For this reason, this issue brief is intended to describe and document health centers' role in meeting the behavioral health needs of low income and at risk populations from a policy, rather than clinical, perspective. Accordingly, this issue brief will not provide a detailed explanation of health center clinical practices. This issue brief also serves as a starting point to delve deeper into health centers' current and future role in providing these services. For the purposes of this brief, "behavioral health" (BH) implies mental health or emotional issues, as well as substance abuse or chemical dependency. There are some exceptions in cases where only one type of service (either mental health or substance abuse) is referenced. While behavioral health could imply any behavioral factor influencing a patient's health status, such as smoking, non-medical adherence, inactivity, and unsafe sexual practices, this issue brief does not use such a broad definition, even though it has been well documented that health centers do operate under such a broad definition of behavioral health and prevention.

With these intentions in mind, this issue brief will provide a broad discussion of the provision of mental health and substance abuse services at health centers and will focus on several key topics, including 1) statistical trends and profiles in the delivery of behavioral health care at health centers; 2) populations at risk for unmet BH needs and how health centers play an important role in meeting these needs; 3) reimbursement and funding of BH services at health

[11] Rosenbaum S, Shin P and Darnell J. *Economic Stress and the Safety Net: A Health Center Update*. Kaiser Commission on Medicaid and the Uninsured. June 2004. www.kff.org/uninsured/7122.cfm.
[12] The federal reporting mechanism through which all federally-funded health centers must report annually.

centers; 4) integration of BH and primary care services at health centers; and 5) areas needing further research and conclusion.

Profile of Behavioral Health Services and Patients at Health Centers

Mental Health and Substance Abuse Services

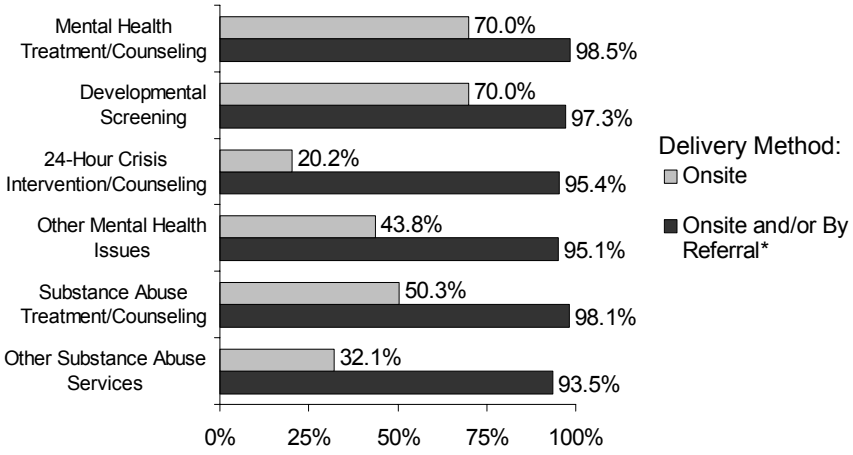
Nearly every health center provides mental health and substance abuse treatment and counseling services onsite[13] or through formal referral arrangements, as seen in Figure 1 below. In 2003, 70% of all federally-funded health centers provided on-site mental health treatment and counseling and 50% provided onsite substance abuse treatment and counseling services. Far more health centers are providing these services onsite than in 1999. That year, 53% of federally-funded health centers provided mental health treatment/counseling and 44% provided substance abuse treatment/counseling.

The service least likely to be delivered onsite at a health center is 24 hour crisis intervention and counseling, with only one in five health centers providing it, but this may be due to workforce and capacity issues curtailing health centers' ability to deliver these services. When also considering formal referrals, nearly all (95%) provide around the clock crisis services. Those health centers that must refer patients to other providers rather than deliver the care themselves usually do so because the patient's condition is severe and requires more intensive treatment, or because health centers do not have the staff and other resources needed to provide the services onsite. Less than 1% of health centers reported that they did not provide any of these services onsite or through referrals. Interestingly, these grantees are scattered around the country, located in both urban and rural settings, and most are not newly established.

It is important to recognize that health centers often face barriers in referring patients to other providers for behavioral health services, including a lack of providers. This is either due to an overall shortage, such as in rural areas, or providers unwilling to accept Medicaid or uninsured patients. Health centers often report these issues anecdotally. This inability to refer patients to other community providers merits further research.

[13] "Onsite" includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers and others such as out-stationed eligibility workers who render services in the health center's name.

Figure 1



* Referrals are provided under formal arrangements. Health center grantees may or may not pay for services received through referrals.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2003 Uniform Data System.

It is interesting to note that homeless health centers (i.e., those with any Healthcare for the Homeless Section 330 funding) are more likely than all other health center types to provide both mental health and substance abuse services onsite. This is likely due to the fact that homeless populations have disproportionately higher rates of BH disorders then the general population,[14] and to increase BH compliance with a mobile and difficult to reach population. Moreover, homeless health centers are also more likely than all health centers to pay for these services provided through formal referrals. The one exception is developmental screening, likely because of their older patient population.

Health centers provide these documented mental health and substance abuse services generally through licensed professional behavioral health specialists, including clinical or counseling psychologists, psychiatrists, clinical social workers, marriage and/or family therapists, psychiatric nurse specialists, or professional counselors. In 2003, federally-funded health centers employed 144.8 full-time employed (FTE) psychiatrists, 1,444.1 FTE mental health specialists, and 676.8 FTE substance abuse specialists. The number of FTE psychiatrists has more than doubled since 1998, and the number of FTE mental health and substance abuse specialists nearly doubled over the same time. Beyond these employed staff, in 2003, federally-funded health centers employed 6,062.5 FTE primary care doctors who often deliver behavioral health services – a growth of 49% since 1998. The fact that the number of FTE behavioral health specialists grew faster than the number of FTE primary care doctors is noteworthy, perhaps speaking to their expanding capacity to provide professional behavioral health services.

[14] National Mental Health Information Center, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. "Homelessness - Provision of Mental Health and Substance Abuse Services." March 2003. www.mentalhealth.samhsa.gov/publications/allpubs/homelessness/default.asp.

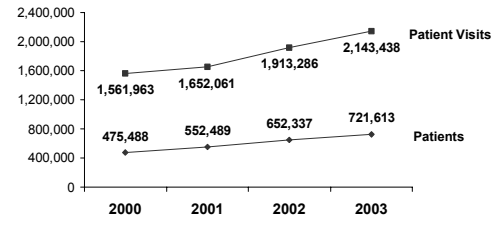
Patients and Encounters

In 2003, 6% of health center patients sought care for mental health conditions directly from the health center, making over 2.1 million clinical encounters, or an average of 2.9 visits a year. Mental health visits are the fifth most commonly reported clinical encounter at a health center. However, when mental health patient encounters are combined with substance abuse patient visits, behavioral health conditions become the number one reported reason for a health center encounter at nearly 2.9 million clinical encounters in 2003, with health supervision of children under 12 a close second, and hypertension a close third.

Figures 2 and 3 below illustrate the growth in the number of patients and clinical encounters for both mental health conditions (Figure 2) and alcohol and drug dependence (Figure 3) from 2000 through 2003. Health center mental health encounters grew 37% while patients receiving mental health services grew 52% over this time period. This may be due to health centers' expanded mental health services capacity during this time, and growing participation in the BPHC Depression Collaborative (to be discussed in greater detail in a later section). During the same period, drug dependence encounters grew 50% and patients grew 14%, while alcohol encounters grew 55% and patients receiving treatment grew 16%. This significant growth is despite the fact that clinical encounters and patients did not consistently grow from year to year. It is likely that encounters for substance abuse services grew faster than patients receiving such services due to health centers' growing intensity for providing these services. Taken together, encounters for mental health conditions and substance abuse grew 41% over the last four years. These encounters grew faster over this time period than the number of encounters for other chronic conditions, namely, asthma (25%), diabetes (31%), hypertension (27%), and heart disease (22%).

Figure 2

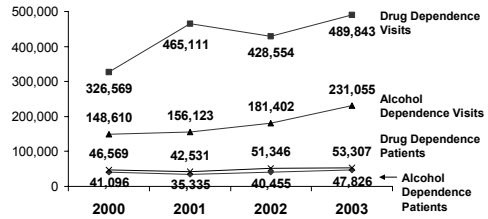
Patients & Patient Visits for Mental Health Services at Health Centers, 2000-2003



Notes: Includes federally-funded health centers. Only includes patients and visits for mental health services as the primary diagnosis.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2000-2003 Uniform Data System.

Figure 3

Patients & Patient Visits for Substance Abuse Services at Health Centers, 2000-2003



Notes: Includes federally-funded health centers. Only includes patients and visits for substance abuse services as the primary diagnosis. Patients for one dependence may also be patients for the other.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2000-2003 Uniform Data System.

While health centers provide far more mental health encounters than substance abuse encounters, they provide far more encounters per patient for substance abuse services than mental health services, speaking to both the level of intensity needed for such services as well as health centers' ability to provide this intensity level (when providing these services onsite). In 2003, health centers provided an average of 3.0 encounters per patient for mental health services, compared to 4.8 for alcohol dependence and 9.2 for drug dependence. Since 2000, alcohol and drug dependence encounters per patient have grown by a third, from 3.6

and 7.0 encounters per patient, respectively, while mental health encounters per patient fell slightly, from 3.3.

While health centers provided nearly 2.9 million mental health and substance abuse encounters in 2003, licensed mental health and substance abuse professional health center staff (including psychiatrists) provided nearly 2.8 million encounters. This difference of 109,000 encounters indicates that health center primary care physicians may be the ones providing these behavioral health services. In fact, 39.4% of health centers in 2003 reported providing any amount of behavioral health encounters without mental health and substance abuse professional staff.

It must be stressed that the level of BH encounters and the percent of patients being treated for BH conditions at health centers are likely to be significantly underreported due to health center reporting requirements around primary as opposed to secondary diagnoses, and also due to reimbursement policies. Because health centers only report encounters by selected primary diagnosis, there is no way to precisely determine how many patients also are treated for behavioral health disorders as a secondary diagnosis. Health center patients tend to be at risk for unmet behavioral health needs, as this issue brief will discuss in detail in a subsequent section. The extent to which any health center clinical staff are treating behavioral health conditions as secondary diagnoses is unclear. Many behavioral health conditions may be discovered during a visit for a physical ailment with a primary care physician, who then serves as the point of entry into behavioral health care even though the behavioral health condition is not identified as a primary diagnosis. Moreover, some payers, including state Medicaid programs, may prohibit reimbursement of primary care providers for BH specialist services. This may therefore discourage health center primary care physicians from using BH diagnostic codes when billing for such services. The extent to which this occurs at health centers is unclear and merits further investigation.

Urban vs. Rural Health Centers in the Provision of BH Services

Health centers are fairly evenly distributed between urban and rural areas. In 2003, slightly more than half (52%) of all federally-funded grantees were located in rural areas. These health centers treated just under half (46%) of all health center patients. Urban health centers are only slightly more likely then rural health centers to deliver mental health and substance abuse services onsite. As for referring patients to these services through formal arrangements *and* paying for them, rural health centers are slightly more likely to do so than urban centers, *except* for substance abuse services, where urban centers are slightly more likely than rural centers to refer out and pay. This could speak to the fact that rural areas have fewer providers in general. Indeed, among primary care providers, the supply of general pediatricians and general internists decreases steadily as urbanization decreases.[15]

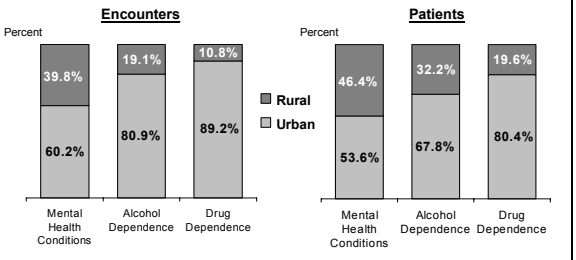
Overall, the bulk of behavioral health patients and encounters are recorded at urban health centers, as seen in Figure 4 below. The disparity between urban and rural health centers is far greater for substance abuse services than mental health services. Lack of available staff at

[15] National Center for Health Statistics. Health, United States, 2001 with Urban and Rural Chartbook. Hyattsville, MD: 2001.

rural health centers may help explain this fact. Figure 5 below illustrates that the majority of behavioral health staff are at urban health centers. Yet, as noted earlier, rural health centers are only slightly less likely to deliver mental health and substance abuse services onsite, and are only slightly more likely to refer patients to mental health and pay for them than urban health centers. Substance abuse treatment is more challenging for rural health centers given their lack of staff. Rural health centers in all probability rely on referring patients to other providers if they exist, especially in the case of substance abuse, and on primary care physicians (PCPs) to provide the bulk of behavioral health treatment. The distribution of PCPs and PCP encounters at urban and rural health centers reflects the national distribution of patients – 45% of full-time employed PCPs and 47% of PCP encounters are in rural settings (not shown in figure).

Figure 4

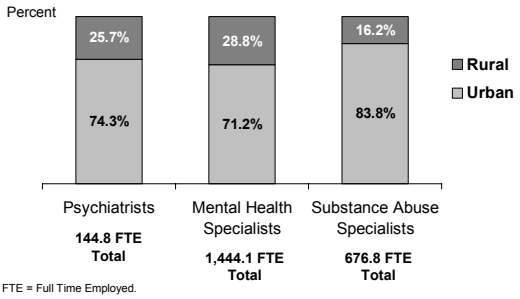
Percent of Mental Health and Substance Abuse Encounters and Patients at Urban and Rural Health Centers, 2003



Source: Bureau of Primary Health Care, HRSA, DHHS, 2003 Uniform Data System

Figure 5

Percent of Behavioral Health Staff at Urban and Rural Health Centers, 2003



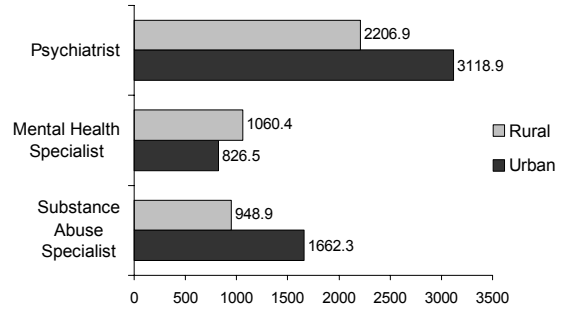
FTE = Full Time Employed.

Source: Bureau of Primary Health Care, HRSA, DHHS, 2003 Uniform Data System

Figure 6 below depicts the average number of encounters per professional behavioral health staff. Urban health centers are providing more encounters per full-time employed psychiatrist and far more encounters per full-time employed substance abuse specialist than rural health centers. However, it is important to recognize that delivered encounters may be underreported and that they do not necessarily reflect the level of need. These encounters per full-time employed clinician may reflect workforce challenges or indicate reliance on referrals. Interestingly, rural health centers are providing more encounters per full-time employed mental health specialist than urban health centers.

Figure 6

Encounters Per Behavioral Health Specialist FTE* at Urban and Rural Health Centers, 2003



* Fulltime employed.

Source: Bureau of Primary Health Care, HRSA, DHHS, 2003 Uniform Data System.

Urban and rural staffing differences in health centers may reflect workforce challenges in rural areas compared to urban areas. Rural areas often face a lack of behavioral health clinicians serving the community from any provider type. In fact, while the BH prevalence in urban and rural settings is about equal, rural areas face severe shortages of BH services. The vast majority of US designated Mental Health Professional Shortage Areas are non-metropolitan and less than 10% of counties with populations under 2,500 have a psychiatrist.[16] Thus, primary care physicians must often fill this need. Of the nearly 39.4% of health centers in 2003 reporting providing any amount of behavioral health encounters without mental health and substance abuse professional staff, a full two-thirds were rural health centers.

State-by-State Health Center Provision of Behavioral Health Services

Appendices A-C provide state-by-state data on the proportion of health centers providing mental health and substance abuse treatment and counseling services, the number of behavioral health clinicians, as well as encounters and patients related to mental health and substance abuse conditions as primary diagnoses. As Appendix A demonstrates, at least 90% of health centers in seven states (**Hawaii**, **Maine**, **Maryland**, **Nevada**, **Utah**, **Vermont**, and **Washington**) and the District of Columbia provide mental health treatment and counseling onsite, compared to the national average of 70%. In addition, at least 75% of health centers in four states (**Hawaii**, **Maine**, **Utah**, and **Wyoming**) and the District of Columbia provide substance abuse treatment and counseling onsite, compared to the national average of 50%. Moreover, while 6% of health center patients nationally had any mental health encounters at health centers, at least 10% of patients in eight states (**Idaho**, **Massachusetts**, **Montana**, **New Hampshire**, **Oregon**, **Vermont**, **Wisconsin**, and **Wyoming**) had any mental health encounters at health centers. Health centers in two of these states (**Vermont** and **Wyoming**) had the highest proportion of patients with mental health encounters at 14%. State variations may reflect reimbursement policy variations, as will be discussed in further detail in this issue brief.

Improving Access to Behavioral Health Services

Unmet Behavioral Health Needs

Behavioral health (BH) problems affect substantial proportions of the population, and services to address these needs must span the lifecycle of patients, and be high quality, accessible, and culturally competent. Such conditions are common and seriously debilitating. One in five Americans over the age of 18 endures a diagnosable mental disorder, and many have co-occurring conditions. Moreover, four of the ten leading causes of disability in developed countries – including the US – are mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.[17] Despite the high level of incidence and the debilitating effects of such conditions, unmet BH needs are pervasive. In 2002, 8.3% of the US

[16] Vanek D. "Rural Facts: Rural Mental Health." Research and Training Center on Disability in Rural Communities, the University of Montana Rural Institute. January 2002. http://rtc.ruralinstitute.umt.edu/MentalHealth.htm.
[17] National Institute of Mental Health, National Institutes of Health, DHHS. "The Numbers Count." 2001. www.nimh.nih.gov/publicat/numbers.cfm.

population over age 18 (17.5 million adults) had a serious mental illness within the past year, and of these, 28.9% also used an illicit drug. While 10.5% of adults received treatment for a mental or emotional problem, of those with co-occurring conditions, just 34% received mental health treatment only, 2% received substance abuse treatment, and 12% received both.[18] Overall, only one-third of Americans with a mental illness or a mental health problem seek care,[19] and other studies show that 50% of those with BH disorders receive care.[20] According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2002 Household Survey on Drug Abuse, 7.7 million individuals were in need of treatment for illicit drug use.[21]

Unmet needs are especially high among racial and ethnic minority groups. The 2001 Supplement to the Surgeon General's Report on Mental Health documented many of these significant disparities among people of color.[22] The supplement found that compared to non-minorities, racial and ethnic minorities nationally have less access to BH services. And despite having similar rates of mental illness overall (though some groups may have higher rates of particular BH illnesses), minorities are less likely to receive needed care or are more likely to receive poorer quality care. Consequently, "minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity." Barriers to BH services include cost of care, stigma, and fragmented service delivery systems, language barriers, providers' lack of understanding cultural issues, bias, and patient mistrust of providers – all barriers health centers are designed to address. Some of the particular examples of disparities the supplement found are listed below.

- The percentage of **African Americans** receiving needed care is only half that of non-Hispanic whites.
- Nearly one out of two **Asian Americans/Pacific Islanders** have difficulty accessing mental health treatment because they do not speak English or cannot find services that meet their language needs. One large study found that only 17% of those experiencing problems sought care.
- Additionally, among **Hispanic/Latino** Americans with a mental disorder, fewer than 1 in 11 contact mental health specialists, while fewer than 1 in 5 contact general health care providers. Among Hispanic/Latino immigrants with mental disorders, fewer than 1 in 20 use services from mental health specialists, while fewer than 1 in 10 use services from general health care providers.
- Only 20% of **Native Americans** report access to Indian Health Service (IHS) clinics, which are located mainly on reservations.

Other distinct population groups are at risk for unmet BH conditions. A few examples are provided below.

---

[18] Based on the National Survey on Drug Use and Health from the Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS. SAMHSA. "Substance Abuse and Mental Health Statistics." http://oas.samhsa.gov.
[19] United States Public Health Service Office of the Surgeon General (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.
[20] Narrow, et al, 1993.
[21] National Survey on Drug Use and Health from the Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS. SAMHSA. "Substance Abuse and Mental Health Statistics." http://oas.samhsa.gov.
[22] United States Public Health Service Office of the Surgeon General (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.

- The **uninsured** are less likely than the insured to receive needed BH services, including children.[23]
- One in 10 **children** in American has a serious behavioral condition and many more go undiagnosed. While parents often can easily identify physical needs, they cannot always recognize mental or behavioral problems when they arise.[24]
- One recent study found that few depressed **Medicaid beneficiaries** received adequate dosage of antidepressants, and that access to these medications were particularly pronounced among African Americans.[25]
- Substance abuse and mental illness among the **homeless** occur at higher rates than the national average.[26]
- The **elderly** are much more susceptible to alcohol abuse than other segments of the population.[27]
- The **chronically ill**, such as those with heart disease and HIV/AIDS, have high rates of depression.[28]
- Residents of **rural** areas have more unmet BH needs then their urban counterparts.[29]

Other population groups may face higher risk for unmet BH conditions, such as single adult households and the disabled.

While those with unmet BH needs do not seek or have access to effective BH services, the cost of not treating them is high. Untreated conditions are associated with higher utilization of health care – somewhere between two and three times the amount of care when compared to those without such conditions.[30] Anxiety and depression among primary care users have been linked to strikingly higher costs.[31] People who report persistent depression have annual adjusted medical costs that are 70% higher than those who do not report having depression.[32]

These populations at higher risk for BH disorders, and especially higher risk for *unmet* BH disorders, face complex barriers to needed care. Improving access to BH services is crucial

---

[23] Mechanic D and Bilder S. "Treatment of People with Mental Illness: A Decade-Long Perspective." July/August 2004 *Health Affairs* 23(4):84-95. Busch SH and Horwitz SM. "Access to Mental Health Services: Are Uninsured Children Falling Behind?" June 2004 *Mental Health Services Research* 6(2):109-16.

[24] American Academy of Pediatrics. "When to Seek Professional Help for Behavior Problems." 2003. www.medem.com/medlb/article_detaillb_for_printer.cfm?article_ID=ZZZVZ2V979C&sub_cat=21.

[25] Melfi CA, et al. "Racial Variation in Antidepressant Treatment in a Medicaid Population." 2000 *Journal of Clinical Psychiatry* 61(1):16-21.

[26] National Mental Health Information Center, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. "Homelessness - Provision of Mental Health and Substance Abuse Services." March 2003. www.mentalhealth.samhsa.gov/publications/allpubs/homelessness/default.asp.

[27] SAMHSA News, Substance Abuse and Mental Health Services Administration, July/August 2004, 12:4.

[28] Koszycki D, et al. "An Open-Label Trial of Interpersonal Psychotherapy in Depressed Patients with Coronary Disease." July-August 2004 *Psychosomatics* 45(4):319-24. Cook JA, et al. "Depressive Symptoms and AIDS-Related Mortality Among a Multisite Cohort of HIV-Positive Women." July 2004 *American Journal of Public Health* 94(7):1133-40. Dunlopp DD, et al. "Arthritis and Heart Disease as Risk Factors for Major Depression: the Role of Functional Limitation." June 2004 *Medical Care* 42(6):502-11.

[29] Calloway M, et al. "Characterization of Rural Mental Health Service Systems." Summer 1999 *Journal of Rural Health* 15(3):296-307.

[30] Simon, 1992.

[31] Simon G, et al. "Health Care Costs Associated with Depressive and Anxiety Disorders in Primary Care." March 1995 *Am J Psychiatry* 152(3):352-7.

[32] St. Luke's Health Initiatives. "Behavioral Health and Disability: A 21st Century Issue." Winter 2003 *Arizona Health Futures* page 4. www.slhi.org/ahf/ahf/AHFWinterIssue2003.pdf.

given that individuals with severe mental and addictive disorders are known to have higher mortality rates than the general population. This higher mortality rate may be due to outcomes of BH disorders (e.g., suicide, illicit drug or alcohol overdose), but they may also be due to access barriers faced in seeking either primary or other medical care or even BH treatment.[33] Barriers to BH services are multifaceted and include cost, fragmented service delivery systems, lack of transportation or available providers, language, and stigma.

Addressing Stigma in the Provision of Behavioral Health Services

Until very recently, public discussions of BH conditions were rare and clouded with myths and misconceptions about those affected by these conditions. Stigma is particularly pronounced among older individuals, ethnic and racial minorities, and residents of rural areas.[34] Further, stigma may prevent individuals from correctly identifying BH symptoms and seeking care.[35] For this reason, among those individuals who seek treatment, many – if not most- prefer to seek BH treatment from their primary care physician. Providing BH treatment services in a culturally competent manner then becomes paramount to ensuring that diverse populations receive behavioral health services in a safe environment that can break down stigma surrounding BH conditions. Health centers are uniquely positioned to successfully confront stigma among the most at-risk populations, as will be described in further detail below.

Improving Access Through Primary Care

Studies have shown that a considerable proportion of people in psychiatric or emotional distress first seek medical assistance from their primary care provider as opposed to other more specialized mental health providers. African Americans, for instance, are more likely than whites to report discussing mental health problems in primary care settings without having seen a mental health specialist, and their reliance on primary care settings for mental health conditions has grown.[36] Primary care physicians deliver half of all mental health care in the US.[37] A more recent study found that the first point of contact for mental health care is usually the primary care provider.[38] One of the top three most commonly prescribed medications for primary care providers are antidepressants,[39] and primary care providers account for more than two-thirds of

---

[33] Pincus H. "The Future of Behavioral Health and Primary Care: Drowning in the Mainstream or Left on the Bank?" Jan-Feb 2003 *Psychosomatics* 44(1):6-8.

[34] United States Public Health Service Office of the Surgeon General (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.

[35] Mojtabi, R., Olfson, M., and Mechanic,D (2002), Perceived Need and Help-Seeking in Adults with Mood, Anxiety, or Substance Abuse Disorders. *Archives of Psychiatry*, 59, 77-84. Sussman, L.K., Robbins, L.N., and Earls, F. (1987), Treatment Seeking for Black and White Americans. *Social Science Medicine*, 24, 187-96.

[36] Cooper-Patrick L, et al. "Mental Health Service Utilization by African Americans and Whites." 1999 *Medical Care* 37(1):1034-45.

[37] Narrow, 1993.

[38] Mechanic and Bilder, 2004.

[39] Centers for Disease Control and Prevention, DHHS. "National Ambulatory Medical Care Survey: 2002 Survey." August 2004. www.cdc.gov/nchs.

all psychoactive agents and about 80% of all anti-depressants prescribed in the US.[40] Primary care physicians therefore play a crucial role in screening, treating, and/or referring patients to appropriate services.

Health centers are the family doctor to 15 million predominately underserved, low income, and minority Americans. Because health centers are required to be open to everyone in the communities they serve regardless of ability to pay, they see a very diverse patient mix, including children and adolescents, the elderly, homeless, and ethnic and racial minorities. As the largest nationally network of primary care safety net providers, health centers reduce or even eliminate multiple and compounding forms of disparities, including those related to age, income, insurance status, race/ethnicity,[41] and geographic residency. As such, they are uniquely posed to serve millions of those with unmet BH needs. In fact, some health centers report that between 50-70% of their patients have a BH disorder.[42] Many health centers also report, at least anecdotally, that BH concerns are one of the primary reasons for a medical visit, beginning with parents' concern for their children and lasting throughout the lifecycle. The previous section of this issue brief documented their increasing level of BH services.

How Health Centers Reduce Barriers to Behavioral Care

Health centers serve disproportionate numbers of low income, minority, and rural Americans. They reduce or even eliminate disparities among their patients through common and often unique features designed to remove multiple barriers to health care, making them different from other community-based health care providers, as well as most private, office-based physicians. These unique characteristics are rooted in their program requirements and are central to their mission and success. Health centers and their services are customized to confront and deal with the complexities of the low income, predominately minority communities who rely on them for care—places where residents typically face more than one barrier to health care and whose residents have disproportionate unmet health needs, including BH. By removing barriers to care, health centers can ensure that patients and potential patients with mental health and substance abuse conditions receive the care they need.

First, health centers are *governed by patient-majority boards* that oversee operations as well as direct the creation and operation of programs tailored to serve their communities' specific needs, such as crisis intervention programs and other specific BH services. At least 51% of these governing boards must be made up of individuals who receive their health care at that center and who represent the community being served. This direct patient involvement in service delivery is key to health centers' accomplishments in serving their communities. Active patient oversight of health centers assures responsiveness to local needs, and helps guarantee that health centers improve their patients' quality of life.

---

[40] Beardsley R, et al. "Prescribing of Psychotropic Medication by Primary Care Physicians and Psychiatrists." 1988. *Archives of General Psychiatry* 45:1117-9.

[41] For a review of literature on this subject and a larger discussion on how health centers specifically reduce or eliminate racial and ethnic disparities, see Proser, M. *The Role of Health Centers in Reducing Health Disparities*. Special Topics Issue Brief #2. National Association of Community Health Centers. July 2003. www.nachc.com/advocacy/HealthDisparities.

[42] Based on email communication with Kirk Strosahl, Mountainview Consulting Group, Inc., August 26, 2004, and Brammer , 2000.

Second, health centers must be located in *high-need areas* identified by the federal government as having elevated poverty, higher than average infant mortality, and where too few physicians practice. By locating in these "medically underserved" areas, health centers improve access for people who traditionally confront geographic barriers to health care, such as rural or homeless patients. Accessibility of patient-centered care is a priority. Thus, many health centers operate during evening or weekend hours, at multiple sites, and through mobile clinics to reach those most in need. This is especially crucial for rural areas. Nearly half (46%) of patients reside in rural areas, compared to 21% of the U.S. population.[43]

Third, health centers must be *open to all* residents, regardless of insurance status or income, and on a sliding fee scale based on ability to pay. Nearly 70% of health center patients have family incomes at or below poverty ($15,206 annual income for a family of three in 2003). Also, nearly 40% of health center patients are uninsured and another 36% depend on Medicaid, much higher than the national rates of 12% and 15%, respectively.[44] Fully two-thirds of all health center patients are members of racial and ethnic minorities. Health centers charge sliding scale fees for out-of-pocket payments based on an individual's or family's income and ability to pay, yet patients unable to meet sliding scale fees are never turned away and many qualify for free care. Thus, health centers eliminate financial barriers to care. For many patients, the health center may be the only source of health care services available. The number of uninsured patients at health centers is rapidly growing – from around 3.9 million in 1998 to over 5.9 million today.

Fourth, health centers must provide *comprehensive primary care and offer services that help their patients access health care*, so-called "enabling services." The vast majority of health centers conduct outreach to identify potential patients and facilitate access to care, as well as translation, transportation, case management, health education, and eligibility assistance for health and social service public assistance programs, including Medicaid and the State Children's Health Insurance Program (SCHIP). Enabling services increase access to and usage of BH care either directly or indirectly through screenings during primary care visits. Health centers *tailor their services* to fit the special needs and priorities of their communities. They provide services in a linguistically and culturally appropriate setting, meaning that staff are often bi- or multi-lingual, patient materials are written in multiple languages, and staff are sensitive to the specific needs and cultural beliefs of their patients. In fact, 95% of all patients report that their doctor speaks the same language as they do, and half of the remaining 5% report that the health center uses a trained translator.[45] Such tailored services help avoid under-use of preventive services and substantial treatment disparities.[46] Beyond providing services in culturally appropriate settings, health centers offer programs beyond medical care suited to specific community needs, such as 24-hour crisis counseling. In addition, they often establish

[43] US Census Bureau. GCT-P1. Urban/Rural and Metropolitan/Nonmetropolitan Population: 2000. http://factfinder.census.gov.
[44] US Census Bureau. *Health Insurance Coverage in the United States: 2002.* Current Population Reports, P60-223. September 2003. www.census.gov
[45] NACHC, Patient Experience Evaluation Report (PEER) Data, 2001.
[46] Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academy Press, 2003. See also IOM, 2002 (citing Grumbach K, Vranizan K, and Bindman A. "Physician Supply and Access to Care in Urban Communities." 1997 *Health Affairs*16(1):71-86.).

partnerships with other non-health related services. For example, many health centers partner with school-based services to care for students.

Fifth, health centers must *follow rigorous performance and accountability requirements* regarding their administrative, clinical, and financial operations. Federally-funded centers are required to report to the federal government information each year on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing. While this reporting does not directly remove barriers to care for patients, it establishes a means of health center accountability for doing so and ensures quality of care. Health centers report the number of encounters for and patients utilizing selected services that are indicators of access to care, such as alcohol and drug dependence and mental health.

Because of their success in removing barriers to care, the Institute of Medicine (IOM) and the General Accounting Office (GAO) have each recognized the success of health centers in reducing or even eliminating health gaps for racial and ethnic minorities and low-income populations. The IOM specifically recognized the importance of community health centers, stating that "the community health center model has proven effective not only in increasing access to care, but also in improving health outcomes for the often higher-risk populations they serve."[47]

Depression Management at Health Centers to Reduce Disparities

Many, if not most, patients with a chronic disease also struggled with an emotional disorder that may affect their adherence to medical treatment, including self-management regimens, and consequently their morbidity and mortality. Managing these co-occurring behavioral health conditions can improve both physical and behavioral health.[48] Moreover, a behavioral health component is also critical for reducing risk for chronic conditions and promoting screenings.[49] Successful management of chronic diseases, therefore, must include a behavioral health component.

Health centers recognize the need for incorporating behavioral health screening and treatment with management of chronic conditions. Approximately 500 health centers nationwide are currently participating in an initiative that aims to improve health outcomes for chronic conditions among the medically vulnerable, particularly low income and underserved minorities. Known as the Health Disparities Collaboratives, and overseen by the federal Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA), the initiative is designed to improve the skills of clinical staff, strengthen the process of care through the development of extensive patient registries that improve clinicians' ability to monitor the

---

[47] IOM, 2003, p. 112. General Accounting Office (GAO). *Health Care: Approaches to Address Racial and Ethnic Disparities*. GAO-03-862R. July 8, 2003.

[48] Lin EH, et al. "Relationship of Depression and Diabetes Self-Care, Medication Adherence, and Preventive Care." September 2004 *Diabetes Care* 27(9):2154-60. Koszycki D, et al, 2004. Cook JA, et al, 2004. Dunlopp DD, et al, 2004. McKellar JD, Humphreys K and Piette JD. "Depression Increases Diabetes Symptoms by Complicating Patients' Self-Care Adherence." May-June 2004 *Diabetes Education* 30(3):485-92.

[49] Akker M, et al. "Is Depression Related to Subsequent Diabetes Mellitus?" September 2004 *Acta Psychiatrica Scandinavica* 110(3):178-83. Pirraglia PA, et al. "Depressive Symptoms Burden as a Barrier to Screening for Breast and Cervical Cancers." July-August 2004 *Journal of Womens' Health* 13(6):731-8.

health of individual patients, and effectively educate patients on self-management of their conditions. Approximately 175,000 health center patients with chronic disease are enrolled in electronic registries for selected chronic conditions, including cardiovascular disease, diabetes, asthma, HIV/AIDS, and depression. Those Collaboratives focusing on physical chronic conditions include a depression screening component. Eventually, every health center will be participating in at least one Collaborative. At least 78 health centers from around the country have implemented a depression Collaborative.

The Collaboratives use the **chronic care model** to strengthen the process of care to meet patient and family needs. The chronic care model employs patient registries to identify and track which patients need care, uses evidence-based guidelines, and effectively involves patients in self-management. This improves clinicians' ability to monitor clinical outcomes and guarantees continuity of care. The Collaboratives were designed to be implemented in care delivery systems quickly and efficiently. Intensive implementation training sessions use a performance-based method of learning that supports teams from several health centers to apply, adapt, share, and generate knowledge about best practices, and to spread constructive changes throughout their health centers and others. In the years following their intensive learning experience, health center clinical teams disseminate best practices to other health centers and continue to report progress on nationally shared measures. Many health centers have spread the practices learned throughout their delivery system.

Health centers participating in the Depression Collaborative adopt standardized national measures based on expert guidelines, external reporting requirements (such as HEDIS), or other community standards of care. Every Collaborative, regardless of chronic condition, measures patient self-management, a concept that is fundamental to the chronic care model. Depression measures include 1) the percentage of patients treated for depression that have a face to face follow up within four to six weeks; 2) the percentage of depressed patients that have patient education materials on depression provided; and, 3) the number of depressed patients who have results of a PHQ-9 (Patient Health Questionnaire) clinical assessment documented in their chart.[50] Health centers participating in Depression Collaboratives have seen improved rates of screening and follow-up.

The Collaboratives increase screenings for registered patients and have led to improved health outcomes for registered health center patients, helping to diminish the health gaps for racial and ethnic minorities as well as the poor in the US. They improve screening for chronic conditions, including depression, and have great potential for reducing the costs of treating chronically ill patients. For example, a study in South Carolina compared total costs for diabetic patients enrolled in the state employees' health plan at different providers, and found that patients treated at a specialist or family practitioner cost more than *three times* as much as those who were treated at a health center.[51] The aim of the Depression Collaborative to integrate routine depression screening as a part of the patient visit will ultimately get patients into behavioral health care earlier, creating savings as conditions are treated before conditions

[50] For more information on measures for depression and other Collaboratives, see www.healthdisparities.net.
[51] Lewis AM. "Improving Care for Diabetic Patients." CareSouth Carolina Community Health Center. Presentation at the Seventh Annual Eye Health Education Conference for the National Institutes of Health's National Eye Institute, Charleston, SC, March 3, 2004.

become more severe and avoiding overuse of primary care services. Indeed, as a result of their success, the IOM commended health centers for providing chronic care management that is "at least as good as, and in many cases superior to, the overall health system in terms of better quality and lower costs," and recommended health centers as models for reforming the delivery of primary health care.[52] The GAO also recently recognized the Collaboratives as a promising federal program targeting health disparities that should be expanded.[53]

The success of the Depression Collaboratives, as well as other Collaboratives, depends on considerable investments of time and infrastructure on the part of the health center in order to improve their capacity for working towards quality improvement. While the BPHC provides technical assistance and software, the average annual cost at most health centers is around $100,000. Health centers receive support for travel to trainings, technical assistance, software, and training materials, and become eligible for IT grants.

Funding Sources for Behavioral Health Care at Health Centers

As health centers expand the provision of BH services and integrate with other primary care services, it is often challenging to obtain adequate funding to expand capacity and receive reimbursement for the cost of care. The landscape against which health centers must find resources and obtain reimbursements for behavioral health services is daunting. With a greater emphasis on screening, diagnosis and treatment, health centers are finding ways to maximize resources. Additionally, the economic downturn for many low-income patients, and the absence of behavioral health providers has also fanned the need for increased funding. Regardless of the delivery model of behavioral health services, health centers are using a number of funding streams to provide these services. However, these multiple federal funding streams may actually be the cause of the fragmented BH system in the US. For example, Medicaid reimbursement may prohibit a physically ill person with depression from seeing a BH specialist the same day.

Health Center Behavioral Health Service Expansions

The Bush Administration and a bipartisan majority in Congress have both committed to expanding the capacity of health centers to serve at least 6 million more patients by 2006. The Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS), where the federal bureau overseeing the health centers program is located, has recognized that, along with the need for access to oral health services, BH services are a critical component of care to health center patients. In fact, during a 2003 speech, Assistant HRSA Administrator Dennis Williams said that, "Currently, mental health is the growth area among all our health center services." With this in mind, HRSA has made special funding available for health centers that wish to expand the reach of their BH services. During fiscal

[52] IOM. *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*. National Academy of Sciences Press, November 2002.
[53] General Accounting Office (GAO). *Health Care: Approaches to Address Racial and Ethnic Disparities*. GAO-03-862R. July 8, 2003.

years 2002 and 2003, health centers have received a total of over $20 million for establishing and expanding these services. Health centers have used this funding in a variety of ways, including adding full-time behavioral health professionals, training and educating primary care professionals, and contracting with local behavioral health providers. For many health centers, this service expansion funding has been critical to their ability to both initiate behavioral health services onsite and expand existing services.

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) houses the federal government's primary prevention and treatment programs. The agency funds a range of BH prevention and treatment activities, primarily through state block grants. According to a NACHC survey of states, most health centers have not received funding for BH activities through SAMHSA, although some centers have been able to secure some limited funding for discreet projects. More recently, by request of HHS Secretary Tommy Thompson, HRSA has reached out to SAMHSA to foster collaboration and encourage integration of primary care and behavioral health services. NACHC and several health centers were pleased to participate in a first-ever national "listening session" earlier last year to provide feedback on these issues. Health centers look forward to ongoing activities, which should provide training and technical assistance to expand health center expertise, expand funding opportunities through both agencies, and facilitate state and local partnerships between health centers and other behavioral health providers. HRSA and SAMHSA intend to move forward in this regard with an action plan based on recommendations made by the New Freedom Commission on Mental Health.

The Importance of Medicaid and Effect of Medicaid Cuts

Medicaid and SCHIP currently cover 36% of health center patients who would otherwise be uninsured. Medicaid is essential for guaranteeing access to diagnostic and specialty services, including intensive behavioral health services. It is this guaranteed access that improves quality of life and patient outcomes. Yet some state Medicaid and SCHIP programs have targeted BH services for cutbacks, and since Medicaid costs continue to increase substantially each year, this trend in service reductions can be expected to continue. NACHC currently is surveying states to determine the extent to which cutbacks over the last year have impacted their patient population and health centers, and the survey's early findings are dramatic. **Texas**, for example, eliminated certain mental health services from its Medicaid program. **Maine**, where the number of health centers providing mental health and substance abuse treatment and counseling is above national health centers averages (see Appendix A), now requires prior authorization for these services. Beyond eligibility and benefits, states may limit access to psychiatric medications through formularies. More research is needed to better determine the extent to which states are limiting access and what drugs may be affected.

Medicaid is a substantial component to states' total mental health budget – covering nearly 50% of state mental health spending.[54] Changes in state Medicaid programs could prevent patients from accessing intensive behavioral health treatment services beyond the ability of health centers to provide. Reducing eligibility and cutting behavioral health services leaves those health centers that are unable to provide these services at the appropriate level of intensity powerless in referring low-income patients to other providers that will see them regardless of their ability to pay. Thus, as explained above, these Medicaid cuts harm low income and often minority populations with significant BH unmet need.

Under federal Medicaid law, Federally-qualified health center (FQHC) services are listed as a mandatory service, which is to say that States *must* offer these services in their Medicaid program. Medicaid law also provides health centers with a form of reimbursement—called the Prospective Payment System (PPS)–that should result in payments to the health centers sufficient to cover their cost in treating their Medicaid patients. Federal Medicaid law defines the services of an FQHC to include (among other things) clinical psychologist services and clinical social worker services, services and supplies incident to these services, and any other ambulatory BH service that a state may include in its Medicaid plan. In fact, the federal statute is written to entitle health centers to reimbursement for BH services provided by clinical social workers or clinical psychologists regardless of whether these services are included in the state's Medicaid plan.[55]

Despite the clear federal mandate, and due to the tight Medicaid environment in many states, it is increasingly difficult for health centers to receive payment for BH services. This is due in part to the separation of payment for mental health versus physical health services in the Medicaid program at the state level, which complicates the integration of BH services; in many cases health centers report that they cannot be reimbursed for the provision of BH services and primary care services delivered on the same day. The increasing number of states turning to managed care for the delivery of behavioral health services to their Medicaid population has further exacerbated this problem. Federal law and policy are clear that even in managed care arrangements, health centers are entitled to be reimbursed under PPS (with the managed care organization (MCO) paying the health center the "going rate", and the State Medicaid agency paying the center the difference). However, MCOs often fail to include FQHCs on their provider panels--thereby denying the Medicaid patient of a service he/she is entitled to under the law. In other managed care instances, some state Medicaid agencies refuse to pay health centers the PPS amount or are very late in getting these payments to the centers. Please see NACHC's Medicare/Medicaid Technical Assistant Issue Brief #78 for a more detailed explanation of these issues.

[54] Mayberg SW. "Medicaid's Future: Navigating Rapids, Rip Tides, and Reform." California Department of Mental Health. Presentation at the National Academy for State Health Policy Conference, Portland, OR. August 4, 2003.
[55] Do Canto LM and Schwartz R. "Medicaid Coverage of Certain Mental Health Services Provided at Health Centers." Medicare/Medicaid Technical Assistance Issue Brief #78. National Association of Community Health Centers. May 2004.

Medicare Reimbursement for Mental Health Services Provided by an FQHC

Throughout the Medicare program, the Federal government only reimburses for mental health services at a fraction of the reimbursement rate for medical services. By law, payment outpatient mental health services is limited to 62.5 percent of covered expenses incurred with the treatment of a mental disorder for a beneficiary who is not hospitalized. This is particularly important for FQHCs, whose reimbursement for certain mental health services (those provided by a psychiatrist, clinical psychologist, and clinical social worker) is reimbursed at 62.5% of their cost of providing those services. Therefore, a health center that chooses to provide certain mental health services to its Medicare beneficiaries does so knowing that it will only receive about 63% of the cost of providing those services.

Health Centers and Behavioral Health Integration/Coordination

In order to simplify and improve issues for individuals in need of both behavioral and primary care, many health centers have hired BH specialists to work as part of the primary care team, and others have created formal partnerships with other BH providers in the community where possible to close gaps and better coordinate care.[56] Although a primary care physician may be the treating physician for these conditions, especially when not severe, in order to improve patients' overall health care, emphasis must be placed on making available a wider range of BH services. Coordinating or integrating BH and primary care services ensures that those with undiagnosed BH conditions do not fall through the cracks.

Traditional BH models provide BH services in separate spaces from primary care and operate under different missions. Such a model is not typical of health centers. Health centers across the country are actively engaging in better care coordination, and have behavioral health delivery systems ranging from relying on separate BH specialists to full integration of care. All health centers, therefore, are providing BH and primary care services within one of the five models briefly described below.

- Model 1: Referral Relationship, where health centers have "preferred" providers and some information exchange.
- Model 2: Co-location, where health centers have onsite BH teams working separately from primary care teams.
- Model 3: Collaborative Care, where health center PCPs have onsite and shared cases with the BH specialist.
- Model 4: Integrated Care, where the BH specialist is an active member of the primary care team.[57]

Based on this typology, desirability increases with each model so that as health centers move towards fully integrated care, they establish a team management approach to delivering BH

[56] Harold Pincus, "The Future of Behavioral Health and Primary Care: Drowning in the Mainstream or Left on the Bank?" Jan-Feb 2003 *Psychosomatics* 44(1):6-8.

[57] Strosahl K. "Integrating Primary Care and Behavioral Health Services: A Compass and A Horizon." Mountainview Consulting Group, Inc. Part of a curriculum for community health centers developed for the Bureau of Primary Health Care Managed Care Technical Assistance Program. For more information, email mconsult@televar.com.

services, and thereby better guarantee continuity of care and adherence to treatment. Traditional models are least desirable in regard to care continuity and treatment adherence. In a fully integrated model, both the BH specialist and the primary care physician share an understanding that BH and medical care are indistinguishable.[58] Thus, a successful integrated care model will provide BH services that are integrated within primary care settings, regarded as a form of primary care, provided in collaboration with a primary care physician, and provided as part of the health care process. In addition, this model aims to enhance the impact of the primary care physician, as well as to consult with and train the primary care physician to produce better health outcomes.[59]

More research is needed to determine how many health centers fall within each applied model. A key factor here is reaching agreement on which BH conditions can be treated by primary health care professionals and which require the services of BH professionals. With appropriate training, primary care providers can conduct BH interventions and treatment in the absence of BH specialists.[60]

Benefits of Integration

Referral-based approaches often prove unreliable as patients may face barriers to following up, especially when the patient is unable to travel to or pay for the services.[61] In order to improve these patients' overall health care, emphasis must be placed on making available a wider range of health services in the most coordinated fashion possible, with a BH component playing a prominent role. Such is the idea behind integrated care. The benefits of integration are far-reaching and include improvements in the process of care, quality of delivered services, health outcomes, and cost-effectiveness. When compared to non-integrated models of care, including referral-based models, integrated care models produce better results, including:

- Improved detection of BH disorders;[62]
- Significant increases in the number of patients receiving recommended care and good clinical outcomes;[63]
- Considerable cost effectiveness of treatment, as much as several hundred dollars per person;[64] and
- Between 20 and 40% of total medical care costs saved, and up to 70% saved in older populations.[65]

Other benefits of integration include:

---

[58] Based on email communication with Kirk Strosahl, Mountainview Consulting Group, Inc., August 26, 2004.
[59] Strosahl K. "Integrating Primary Care and Behavioral Health Services: A Compass and A Horizon."
[60] Aoyama MC. "Integrating Primary Care Benefits All Involved." Summer 2003 *Networks* 8(1&2):3. www.nasmhpd.org/general_files/publications/ntac_pubs/networks/summer2003networks-4.pdf.
[61] Kanapaux W. "The Road to Integrated Care: Commitment is the Key." April 2004 *Behavioral Healthcare Tomorrow* 13(2):10-2, 15-6.
[62] Katon W, et al. "Adequacy and Duration of Antidepressant Treatment in Primary Care.: January 1992 *Medical Care* 30(1):67-76. Katon, et al, 1990.
[63] Quirk, et al, 2000.
[64] Von Korff M, et al. "Treatment Costs, Cost Offset, and Cost-Effectiveness of Collaborative Management of Depression." March-April 1998 *Psychosom Med* 60(2):143-9.
[65] Based on a review of literature. See Strosahl K. "Integrating Primary Care and Behavioral Health Services: A Compass and A Horizon."

- Facilitation of diagnoses and treatment related to or resulting from a physical illness;
- Monitoring and collaborating on medication use (since some BH specialists cannot prescribe medications);
- Quality improvement initiatives and the adoption of evidence-based practices in both BH and primary care;[66]
- Communication among providers, which leads to better coordination of care and fewer clinical errors;
- Patient and family satisfaction; and
- Opportunities for teaching and learning across healthcare disciplines.[67]

Challenges to Integration

Many challenges exist to integrating and improving the coordination of BH services. Practical obstacles may include a lack of awareness of local providers and their respective models of care, including referral and contracting, and billing and reimbursement issues, and understanding the unique needs of the individuals served by health centers.[68] In some cases, local BH providers have experienced decreases in state and federal BH funding that may make it difficult to successfully partner with health centers. Other challenges include learning and applying new skills to form a clinical partnership, and building referral relationships with non-health center providers for more intensive treatment beyond the ability of the health center.[69] Integration also demands financial, structural, as well as clinical support in order for it to be successful and truly comprehensive.[70] The additional staff needed must be trained in delivery of culturally competent care and may be in short supply, as is the case in rural areas.

[66] The National Advisory Committee on Rural Health and Human Services. The 2004 Report to the Secretary: Rural Health and Human Services Issues: April 2004.
[67] Washington Community Mental Health Council. "Guiding Principles for Integration: Mental Health and Primary Care." Adopted December 5, 2002. www.wcmhcnet.org/StaticContent/1/Resources/WCMHCGuidingPrinciples.htm.
[68] Kanapaux, 2004.
[69] Aoyama, 2003.
[70] Pollack DA. "Behavioral Health/Primary Care Integration." Presentation at National Council for Community Behavioral Healthcare, March 2003. See also, Kanapaux, 2004.

A Health Center Integration Example:
Cherokee Health Systems, Talbott, TN

Health centers have long histories of co-locating behavioral health care with primary care, and many have long-established integrated models. One such health center is Cherokee Health Systems, a Tennessee health center, which originally began as a community mental health center before becoming a federally-qualified health center. Cherokee recognized the increasing need – and even demand – for behavioral health services administered in primary care settings, and thus developed and expanded their ability to deliver comprehensive care to their own patient base.

Cherokee Health System opened its first integrated site in 1984 and now has 18 locations, 15 of which are integrated sites. Team-oriented approaches have helped them 1) thrive despite a backdrop of benefit cutbacks particularly in the behavioral health services arena, 2) focus on improving screening and identification of behavioral health problems in primary care settings, and 3) facilitate communication among providers. According to Cherokee, the placement of a behaviorist on each primary care team is crucial to their mission to help ensure that the patients will get the appropriate behavioral care prescribed and recommended.

Source: Kanapaux W. "The Road to Integrated Care: Commitment is the Key," April 2004 *Behavioral Healthcare Tomorrow* 13(2): 10-2, 15-6.

Conclusion and Next Steps

There are several remaining questions this issue brief was unable to address in documenting the role of health centers in delivering BH care and reimbursement policies affecting their ability to do so, including:

- The impact of Medicaid cuts and other policy changes on access to BH services across the lifespan;
- The extent to which SAMHSA and state governments provide direct funding to health centers and how this funding is used;
- Whether and the extent to which health center primary care providers delivering BH services are discouraged from using BH diagnostic codes due to reimbursement policies;
- The impact of workforce issues that may affect delivery of BH services, such as the lack of trained professionals, licensing issues, and reimbursement for care;
- The extent to which health centers are providing BH prevention, diagnosis, and treatment in correctional institutions;
- Whether health centers with integrated BH models have higher primary care visits per patient than those that do not;
- How often health centers need to refer patients to more intensive behavioral health services, which health centers face barriers to referring patients for such services and why; and
- Evaluate partnerships between health centers and other community-based organizations, such as schools and other providers, to delivery BH services.

In addition to these research questions, NACHC is also considering conducting a case study of multiple health center behavioral health programs. This would provide a closer look at how health centers coordinate or integrate BH and primary care programs, how they provide

these services in culturally and linguistically appropriate settings, how these models of care are funded, and how effective these programs are. Because health centers vary greatly in their service delivery approach, such a case study would shed light on the different models health centers use. It would also assist other health centers as they more towards integration.

Regardless of this additional research necessary, it is abundantly clear that behavioral health stands out as a compelling and immediate issue facing the national health care system and health centers more directly. Clearly, controlling health care costs requires that behavioral health needs be adequately addressed. Health centers have already made impressive strides towards the culturally competent integration of BH and primary care services to better address the needs of the broad population seen at health centers. However, there remain challenges as health centers continue to expand their capacity to better meet the behavioral health care needs of their patients.

Above all, there is, first, a need for increased resources and improved reimbursement for health centers to expand their behavioral health services, and allow centers to further leverage BPHC BH service expansion funding to obtain SAMHSA resources and funding at the state level, and better partner with other behavioral health providers; second, the need for parity in the coverage of BH and substance abuse treatment in order to ensure that greater numbers of the nation's health care safety net have access to behavioral health services; and third, the need for additional research on behavioral health and health disparities in order to better understand the gaps in prevention and treatment and to better care for these populations at health centers.

Appendix A

Percent of Health Center Grantees Providing Mental Health and Substance Abuse Treatment and Counseling Onsite* By State, 2003

State	# of Health Center Grantees	Mental Health Treatment and Counseling	Substance Abuse Treatment and Counseling
Alabama	15	60%	27%
Alaska	21	76%	62%
Arizona	14	79%	71%
Arkansas	10	50%	60%
California	83	70%	54%
Colorado	15	80%	73%
Connecticut	10	80%	60%
Delaware	3	33%	0%
District of Columbia	2	100%	100%
Florida	32	63%	38%
Georgia	22	50%	36%
Hawaii	10	90%	80%
Idaho	7	71%	57%
Illinois	31	77%	55%
Indiana	11	55%	27%
Iowa	8	63%	50%
Kansas	8	75%	38%
Kentucky	12	58%	50%
Louisiana	16	56%	38%
Maine	12	92%	75%
Maryland	13	92%	69%
Massachusetts	33	67%	52%
Michigan	26	69%	31%
Minnesota	12	75%	50%
Mississippi	21	38%	48%
Missouri	17	88%	59%
Montana	11	73%	73%
Nebraska	5	80%	40%
Nevada	2	100%	50%
New Hampshire	7	57%	71%
New Jersey	16	81%	63%
New Mexico	14	79%	50%
New York	51	88%	49%
North Carolina	25	64%	48%
North Dakota	5	40%	40%
Ohio	21	67%	43%

State	# of Health Center Grantees	Mental Health Treatment and Counseling	Substance Abuse Treatment and Counseling
Oklahoma	6	83%	67%
Oregon	16	75%	69%
Pennsylvania	29	72%	48%
Puerto Rico	20	45%	40%
Rhode Island	6	83%	33%
South Carolina	21	62%	38%
South Dakota	7	71%	14%
Tennessee	23	65%	52%
Texas	35	57%	29%
Utah	11	100%	82%
Vermont	3	100%	67%
Virginia	18	61%	50%
Washington	22	91%	50%
West Virginia	27	78%	67%
Wisconsin	14	64%	50%
Wyoming	4	75%	75%
United States**	890	70%	50%

* “Onsite” includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers and others such as out-stationed eligibility workers who render services in the health center's name. Grantees may also provide these services through formal referral arrangements.
** US totals include American Samoa, Fed. States of Micronesia, Guam, Marshall Islands, and Palau.

Source: NACHC, 2004. Based on Bureau of Primary Health Care, HRSA, DHHS, 2003 Uniform Data System.

Appendix B

Full-Time Employed Behavioral Health Clinicians and Related Encounters By State, 2003

State	Psychiatrist FTE	Psychiatrist Encounters	Mental Health Specialists FTE	Mental Health Specialist Encounters	Substance Abuse Specialists FTE	Substance Abuse Specialists Encounters
Alabama	0.15	1937	2.8	4278	7.79	7926
Alaska	0.23	191	27.35	4478	29.68	3173
Arizona	0.07	267	19.51	14257	1	991
Arkansas	0	0	0.6	589	0	0
California	14.14	32287	223.99	248342	133.54	239981
Colorado	3.78	7301	38.49	35451	9.66	7941
Connecticut	5.79	14792	41.74	41284	39.24	30814
Delaware	0.01	259	0	0	0	0
District of Columbia	3.53	7904	5.23	5579	0.3	1070
Florida	9.18	38210	39.13	37554	36.81	25234
Georgia	0.1	301	2.29	1814	7.63	38702
Hawaii	9.78	10321	22.36	16869	5.35	4373
Idaho	0.81	1906	8.11	6882	0.76	223
Illinois	5.16	12308	139.29	72957	14.62	7715
Indiana	0	0	8.34	4547	0.56	764
Iowa	0	0	6.46	2971	0.37	98
Kansas	0	1	3.48	2331	2.31	3460
Kentucky	0.53	810	6.22	5799	2.79	1299
Louisiana	0.9	1408	6.83	5000	13.08	43393
Maine	1.25	2243	11.84	10414	6.37	4743
Maryland	6.81	14899	25.13	28360	29.61	25471
Massachusetts	9.53	21430	131.43	117787	34.07	31427
Michigan	1	1863	21.19	20041	8.25	20559
Minnesota	1.22	3088	36.54	30651	3	2745
Mississippi	1	2989	3.65	2624	1.81	2332
Missouri	3.87	14082	23.38	18821	12.48	61475
Montana	0.17	115	5.26	3878	1.31	1673
Nebraska	0.12	201	1.75	1634	0	0
Nevada	0	0	1	331	0	0
New Hampshire	0	0	2.32	2222	2.69	2549
New Jersey	2.88	5407	16.16	6899	10.49	8175
New Mexico	2.77	6026	63.27	50995	3.53	10411
New York	29.14	137064	126.99	153579	95.07	206023
North Carolina	0.62	2719	10.33	7750	3.42	5282
North Dakota	0	0	0.5	200	0.38	688
Ohio	1.61	4826	12.66	9460	13.54	7248
Oklahoma	1	3248	11.99	30167	0.17	588

State	Psychiatrist FTE	Psychiatrist Encounters	Mental Health Specialists FTE	Mental Health Specialist Encounters	Substance Abuse Specialists FTE	Substance Abuse Specialists Encounters
Oregon	1.92	5748	63.61	34712	65.56	67661
Pennsylvania	3.39	9339	49.05	34965	11.47	14112
Puerto Rico	2.9	8862	15	23340	12.52	13791
Rhode Island	0.3	499	3.87	4842	0.1	83
South Carolina	0.27	698	16.88	17844	3.25	2271
South Dakota	0.05	174	2.28	1405	0.03	891
Tennessee	0.78	753	7.7	6192	4.95	20874
Texas	1.58	2780	24.67	26010	12.57	84888
Utah	0	0	9.89	6793	0	0
Vermont	0.8	905	6.16	6000	1	638
Virginia	0.34	1307	9.3	7198	1.5	1884
Washington	3.08	4496	76.62	54346	26.09	25364
West Virginia	2.73	8027	23.11	29244	1.3	1496
Wisconsin	9.51	23718	23.12	29251	2.1	3084
Wyoming	0	0	3.06	1412	1.5	807
United States*	144.8	417709	1444.13	1290862	676.82	1046867

FTE = Full-time employed.

*US totals include American Samoa, Fed. States of Micronesia, Guam, Marshall Islands, and Palau.

Source: NACHC, 2004. Based on Bureau of Primary Health Care, HRSA, DHHS, 2003 Uniform Data System.

Appendix C

Encounters and Patients Related to Mental Health and Substance Abuse as Primary Diagnoses, and Percent of Patients with Any Mental Health Encounters By State, 2003

State	Total Patients	Primary Diagnosis Encounters and Patients				% Patients With Any Mental Health Encounters
		Substance Abuse Encounters	Substance Abuse Patients	Mental Health Encounters*	Mental Health Patients	
Alabama	296,048	1,689	1,233	19,194	12,102	4%
Alaska	64,490	2,924	957	6,399	2,845	4%
Arizona	233,151	2,116	1,016	26,323	11,184	5%
Arkansas	105,920	657	393	11,088	5,883	6%
California	1,655,439	185,051	12,927	263,769	82,267	5%
Colorado	372,590	6,918	2,813	63,616	22,276	6%
Connecticut	171,611	39,355	6,196	59,253	12,620	7%
Delaware	18,191	72	54	1,517	876	5%
District of Columbia	58,202	3,586	1,459	4,689	2,046	4%
Florida	562,585	17,281	4,177	112,966	36,373	6%
Georgia	221,367	42,409	819	16,177	9,229	4%
Hawaii	75,218	6,334	1,110	35,580	5,541	7%
Idaho	69,195	495	215	17,537	6,843	10%
Illinois	646,343	3,517	1,485	114,765	29,465	5%
Indiana	117,948	510	342	7,274	4,613	4%
Iowa	86,338	545	271	8,576	4,604	5%
Kansas	49,736	98	51	5,948	2,590	5%
Kentucky	176,899	525	376	19,159	10,546	6%
Louisiana	87,475	4,341	882	5,262	3,689	4%
Maine	81,519	5,845	1,077	27,030	7,614	9%
Maryland	156,025	29,638	4,441	37,192	8,563	5%
Massachusetts	402,078	42,803	5,804	145,178	38,585	10%
Michigan	380,036	11,159	3,744	49,109	24,925	7%
Minnesota	117,262	2,424	1,061	35,401	8,505	7%
Mississippi	301,301	2,236	1,213	22,868	10,860	4%
Missouri	251,302	62,433	2,805	55,405	18,408	7%
Montana	57,910	1,530	587	18,239	7,916	14%
Nebraska	30,374	122	51	4,024	1,808	6%
Nevada	54,261	211	180	3,627	2,366	4%
New Hampshire	39,550	940	619	9,751	4,959	13%
New Jersey	218,149	8,070	1,809	11,686	5,810	3%
New Mexico	208,588	3,659	1,432	59,327	14,634	7%
New York	1,005,290	97,877	12,626	233,376	54,569	5%
North Carolina	272,314	1,308	642	23,732	11,322	4%
North Dakota	15,402	880	186	1,722	1,047	7%

State	Total Patients	Primary Diagnosis Encounters and Patients				% Patients With Any Mental Health Encounters
		Substance Abuse Encounters	Substance Abuse Patients	Mental Health Encounters*	Mental Health Patients	
Ohio	275,200	8,567	1,174	41,752	19,235	7%
Oklahoma	72,356	169	126	33,308	4,477	6%
Oregon	155,678	66,526	5,191	67,716	15,985	10%
Pennsylvania	411,841	8,621	4,761	58,342	24,215	6%
Puerto Rico	402,934	6,532	3,002	23,665	13,528	3%
Rhode Island	76,803	177	126	11,448	4,921	6%
South Carolina	265,946	3,794	1,378	28,776	13,681	5%
South Dakota	47,392	1,219	585	6,603	2,859	6%
Tennessee	211,549	3,775	747	18,296	10,030	5%
Texas	547,816	4,464	1,201	43,177	21,933	4%
Utah	80,347	514	366	10,764	5,950	7%
Vermont	31,806	1,717	512	12,429	4,519	14%
Virginia	158,483	2,917	447	23,409	11,274	7%
Washington	531,177	12,720	3,652	111,041	44,065	8%
West Virginia	257,029	5,010	1,783	53,893	20,572	8%
Wisconsin	128,222	4,017	820	56,261	14,707	11%
Wyoming	14,257	351	115	5,183	1,977	14%
United States**	12,391,270	720,898	101,133	2,143,438	721,613	6%

* Includes mental retardation. However, these patients and related visits make up a small proportion.

**US totals include American Samoa, Fed. States of Micronesia, Guam, Marshall Islands, and Palau.

Source: NACHC, 2004. Based on 2003 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.