



Mental Health Is Primary Care: Policy Lessons from Advanced Primary Care Investment

Presentation to the Mental
Health Integration Workgroup
of the MHLG

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Why This Matters

- **Mental health access crisis is showing up in primary care**
- U.S. primary care is **underfunded** leading to burnout, shortages, and fragmented services—which **limits access to primary care behavioral health**
- States, payers, and federal agencies are increasing primary care payments—but **how should new dollars be invested to best support mental health within primary care?**

Study Purpose

Goal: Provide actionable guidance (through an investment guide) to provider organizations, primary care practices, health plans, and policy makers on *where* to invest in advanced primary care (APC) to improve outcomes, equity, and cost.

- To learn from stakeholder organizations making investments in primary care
 - how they have prioritized spending on advanced primary care services.
 - experiences of facilitators and barriers to investment, the impact of investments and lessons for those considering investment.
- To conduct systematic reviews of the peer-reviewed published research on the impact of advanced care services on health care costs, quality, and equity.

Methods Overview

Mixed-methods study:

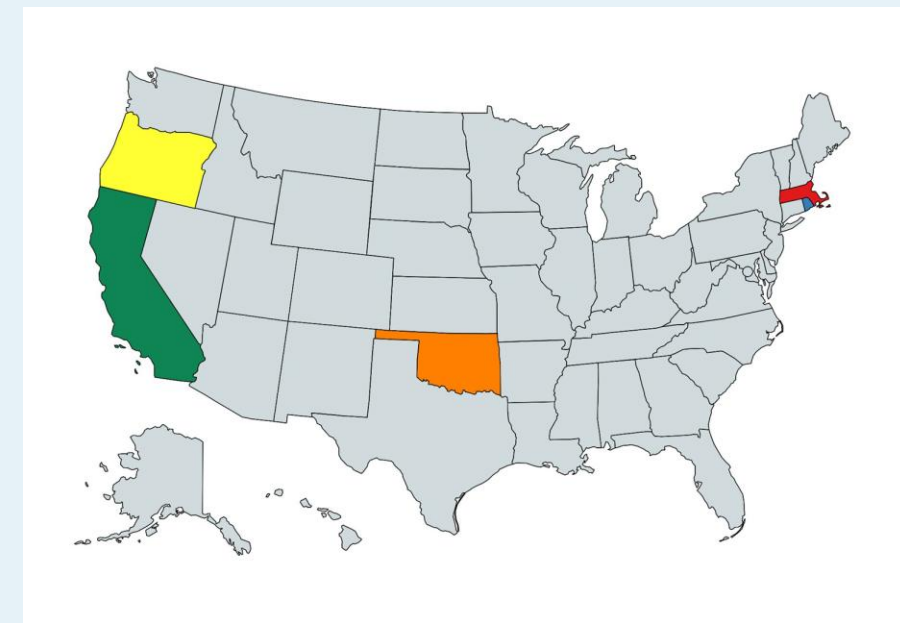
Qualitative:

- State-data agency supported sample of organizations leading in APC investment
- Interviews: provider organizations (20), practices (16), and payers (6) across 5 states
- Spending reports: provider organizations (6) and practices (10)

Rapid literature reviews:

- 6 advanced primary care services
- Impact of services on cost and utilization
- 200+ studies

Output: Synthesized evidence + real-world practice insights to guide investment decisions.



Key finding 1: Behavioral health integration is central to advanced primary care

BHI embeds mental health, substance use, and behavioral health services into primary care to support whole-person care. Two major models:

- Primary Care Behavioral Health model
- Collaborative Care Model
- Also: co-located clinicians, centralized referral networks, tele-behavioral health, e-consults, psychiatry consultation, open-access slots, and warm handoffs

No single model works everywhere; models varied by staffing, patient population, community resources, and financial capacity.

So, this is a (collaborative care) program that I think has been really beneficial again to both patients and providers...when we first began working with a lot of our providers, one of the biggest concerns that they had about caring for their patients was getting them access to behavioral health.

Key finding 2: Workforce shortages are the binding constraint

Limited access to psychiatrists, forcing primary care teams to manage higher-acuity behavioral health needs.

Shortages also affect licensed behavioral health clinicians and make fully embedded models hard to scale.

Consultative psychiatry, e-consults, tele-psychiatry, and team-based behavioral health roles are strategies to extend limited specialist capacity.

We do not have a psychiatrist who's been with us for some time... there's such a need for that, and there is still work to be done. Considering how many patients we have, we don't have enough (behavioral health access).

Key finding 3: Reimbursement rarely covers the true cost of integration

Organizations see the value of BHI, but reimbursement often does not cover the full cost.

Leaders described financial sustainability as one of the central barriers.

BHI results in indirect ROI through fewer ED visits, fewer hospitalizations, reduced readmissions, better chronic disease control, and better clinician support. But if savings do not flow back to primary care practices, programs remain financially fragile.

We've never been able to figure out how to sustain that integrated model where you have the concept of a behavioral health clinician, where you're doing these warm handoffs that may or may not happen. In the meantime, who's paying the salary of that behavioral health clinician?

Key finding 4: BHI supports equity, but only when paired with navigation and social support

BHI can improve access for vulnerable populations, especially when social workers, community health workers, and behavioral health navigators help patients move through complex referral networks and address social determinants of health.

Equity impact results are mixed, but several studies showed reduced disparities or greater improvement for non-White and Spanish-speaking patients.

Policy implication:

Equity-oriented BHI requires navigation, language access, culturally responsive care, social needs supports, and accountability for outcomes stratified by race, ethnicity, language, insurance, geography, and other relevant factors.

Key finding 5: Social needs are inseparable from mental health access

SDOH interventions are increasingly integrated into primary care through screening, referral, CHWs, CBO partnerships, and rapid-response funds for urgent needs.

Housing was consistently identified as the hardest domain because it is resource-intensive, slow to resolve, and often outside the control of the health care sector.

Policy implication:

BH policy should support cross-sector partnerships among primary care, BH providers, housing, food, transportation, legal aid, and community-based organizations.

Key finding 6: Care management is a mental health policy issue

Care management provides support for high-risk and high-need patients, addressing both medical and psychosocial needs.

ROI is highest when programs target patients at greatest risk of hospitalization, and when behavioral health and social service interventions are incorporated.

Organizations reported lower acute care utilization, improved chronic disease outcomes, and reduced clinician burnout through shared responsibility for complex cases.

Policy implication:

Mental health advocacy should include payment for care management, transitions support, discharge follow-up, and navigation, especially after psychiatric hospitalization or crisis episodes.

Key finding 7: Technology helps, but it is not the model

Tele-behavioral health, tele-psychiatry, e-consults, remote monitoring, registries, AI-enabled tools, and centralized analytics as useful strategies to extend capacity.

Successful models still depend on trusted relationships, workflows, team roles, and payment.

Policy implication:

Telehealth and digital tools should be funded as part of integrated care infrastructure, not as substitutes for behavioral health workforce, team-based care, or longitudinal relationships.

What policymakers should take from this

1. Increase primary care investment with accountability for behavioral health integration.
2. Move toward prospective, hybrid payment.
3. Ensure funds reach the frontline team.
4. Reduce (or eliminate) patient cost-sharing for integrated care.
5. Fund workforce and infrastructure.
6. Align payers and simplify measures.

The hospital made some major investments in behavioral health and that did not come from a change in value-based care. It came from too many patients in the emergency room and the hospital wards.

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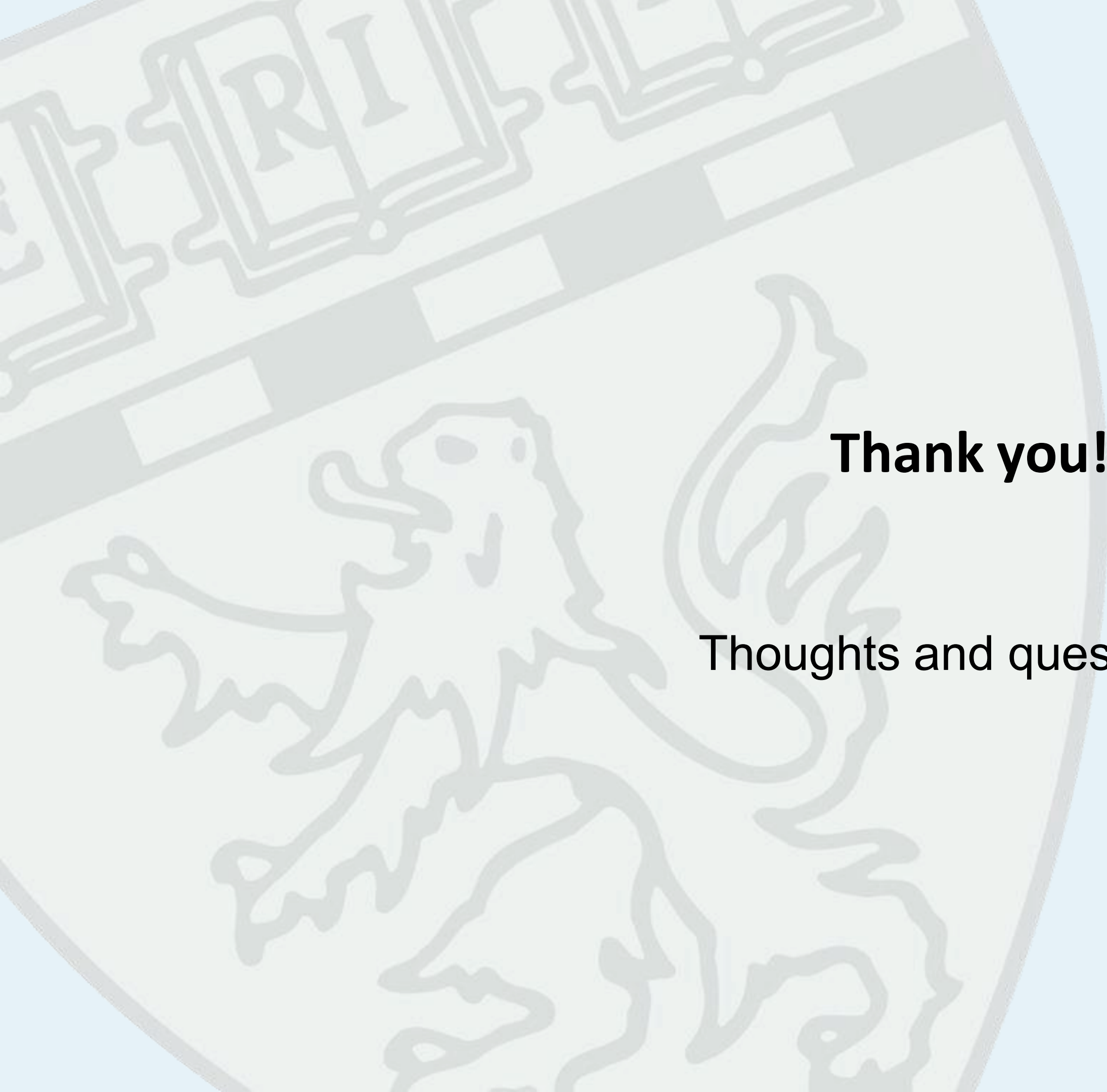
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Primary Care Investment Guide



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Thank you!

Thoughts and questions?