ORIGINAL RESEARCH

Exploring North Carolina's Transition to Whole-Person, Integrated Care From the Provider Perspective: Results From an Exploratory Survey

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BACKGROUND For quite some time, many North Carolina practitioners and health care leaders have advocated for whole-person care. There has been significant movement toward a whole-person approach to health in the state; however, challenges remain despite continuous momentum building over the years. This article reports an exploratory survey with North Carolina primary care and behavioral health providers.

METHODS Providers were recruited statewide through professional associations and networks to participate in a survey regarding their experience delivering whole-person care. The survey included demographic, provider, and clinic type information; professional experience; and 46 questions focused on whole-person care practice.

RESULTS The results of the survey demonstrated that providers report more acknowledgment and attempted practice of whole-person care, but there are still barriers to overcome, such as relieving the administrative burden of changing or expanding services, understanding reimbursement for integrated services, and difficulty recruiting and retaining providers.

LIMITATIONS The sample included more nurse practitioners than other primary care and behavioral health disciplines. Thus, the information gathered in this survey may be more representative of the training and experience of nurse practitioners than of a paradigm shift in North Carolina in the delivery of care. Additionally, while researchers made every attempt to distribute the survey statewide, some areas of the state were more represented than others.

CONCLUSION Obstacles to seamlessly providing whole person care remain. State health leaders, providers, and North Carolina communities will need to work together to reduce or eliminate these obstacles and ensure the delivery of integrated behavioral health and whole-person care.

In the early 2000s, North Carolina began to formalize conversations and working groups around developing and implementing whole-person care (WPC) approaches. WPC is widely recognized globally and is commonly thought of as "an approach that considers multiple dimensions of the patient and their context, including biological, psychological, social and possibly spiritual and ecological factors, and addresses these in an integrated fashion" [1]. Part of the goal of transitioning North Carolina's Medicaid program to managed care prepaid health plans (PHP) is to implement WPC in the state in a way that will "...prioritize the health of the whole person to make North Carolinians healthier overall" [2]. The move toward value-based care will validate what providers of various disciplines have long known: that patients should be treated and cared for as whole people.

A significant part of WPC is integrating and coordinating traditionally siloed health services, such as primary care and behavioral health. We have long known that most patients in a primary care setting have presenting concerns stemming from a psychosocial issue. Researchers have touted the benefits of integrating behavioral health and primary care for patient outcomes and provider satisfaction [3–6]. To successfully integrate behavioral health and primary care, the clinical, operational, and financial sectors must work seamlessly together, demonstrating what is known as the 3-world view [7]. This concept drives home the point that for a practice to successfully deliver WPC, the care provided must be clinically effective, it must not put a strain on the individuals carrying out the labor of its delivery, and it must be financially sustainable. Often, providers are the first to know what a patient needs, whether pharmaceutical, procedural, or behavioral health interventions. Still, there are times when the best clinical care faces obstacles related to policy and reimbursement (i.e., the operational and financial worlds of health care). The purpose of this article is to explore the provision of WPC, with a focus on the integration of behavioral health into primary care and its delivery by North Carolina health care providers. This exploration illuminates both the strengths of the North Carolina system and its challenges. WPC and integrated care are inclusive of many strategies, methods, and types of care. However, behavioral health integration has received particular attention due to its traction in North Carolina and nationally. First, it is essential to look

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back through literature and policy to understand the current and past contexts for WPC in North Carolina.

History of North Carolina's Paradigm Shift

North Carolina is in the midst of a health care system change through Medicaid transformation, for which planning began in 2017. With the inclusion of value-based payments and the evidence supporting improved patient outcomes when behavioral health is integrated into primary care, this transformation should provide additional support to WPC. North Carolina health clinics have been practicing WPC through programs of integrated behavioral health care even without the necessary organizational and financial infrastructure [8]. The work of integrated WPC bloomed in the West in the early 2000s, through the North Carolina Area Health Education Center's (NC AHEC) Mountain Area Health Education Center (MAHEC) Women's Clinic, then followed by MAHEC Family Medicine [9]. The effort spread both in clinical practice and in grant funding to support the development and proliferation of WPC in the region and beyond. For example, the program ICARE, housed in the Foundation for Health Leadership and Innovation (FHLI; formerly known as the North Carolina Foundation for Advanced Health Programs), was founded to work directly with clinics and the workforce to advocate and advise on policy development to further integrated care [10]. While the ICARE work continued and still lives on through FHLI's Center of Excellence for Integrated Care over a decade later, it initiated a movement for North Carolina to support integrated care by removing financial hurdles and promoting screening and workflows supportive of integrated care [11].

The groundswell of support for integrated care continued, as evidenced by examples referenced in the literature. Clinics and researchers zeroed in on high-need areas, such as diabetes, pediatric health, severe mental illness, and social determinants of health [12–17]. The research and clinical worlds came together also in the variety of integrated care models and programs implemented across the state, including co-location, the primary care behavioral health (PCBH) model, the collaborative care model, and reverse co-location [18–21].

While these efforts were being made on the clinical front and backed by research, legislation and other infrastructure seemed to go back and forth from moving toward a system designed for integration and WPC to one that appeared to be limiting [22–25]. One recent successful step toward building a solid infrastructure for integrated care included opening the Centers for Medicare and Medicaid Services (CMS) G-codes. The codes were endorsed in North Carolina and allow reimbursement for collaborative care treatment for Medicaid beneficiaries as of 2018. (The standard plans of Medicaid transformation launched successfully in July 2021.) The planned launch of the tailored plans has been delayed until April 2023 to allow for more preparation.

Many practices across the state are working toward integrating behavioral and physical health services; however, with varying financial resources, human capital, and integrated care knowledge at their disposal, these often change-fatigued practices are only able to implement pieces of the integrated care puzzle. A complete paradigm shift toward WPC delivered through integrated care models requires everyone from the front desk to the primary care provider and the patient to understand, appreciate, and destigmatize the connection between the mind and the body. While many entities across the state are working toward better integrated care, the current state of integration in North Carolina is unknown. The purpose of the survey reported in this article is to give a voice to the North Carolina providers who have been working on the front lines of whole-person integrated care. The survey explores the reality of the successes and challenges of providing WPC from the provider's point of view in North Carolina.

Methods

A survey of the familiarity with and delivery of WPC for providers was developed, pilot tested among a small multidisciplinary group, and refined further based on feedback. The survey included demographic, provider, and clinic type information; professional experience; and 46 questions focused on characteristics of service provided at participants' place of employment (e.g., "True or false, our clinic has a written protocol for sharing information with external behavioral health providers"). When asked about WPC, participants were asked to consider the following definition: "Whole-person care is considered a multidimensional, integrated approach to care that addresses multiple aspects of health, including biological, psychological, and social aspects" [1]. Participants were excluded if they did not work in a primary care setting or were not one of the provider types included in the survey (primary care or behavioral). There were 2 different sets of questions based on whether or not participants indicated they had a behavioral health person on site at their clinic.

The UMCIRB approved the survey and project at UNC-Chapel Hill (Study #: 19-1593), and researchers created the survey in the software Qualtrics for dissemination. Participants were recruited through professional licensure associations, health care associations, a Medicaid bulletin, the 2019 North Carolina Integrated Care Symposium, and snowball sampling from these processes and networking relationships. Participants were directly sent a recruitment email and link to the survey, including the informed consent and background information. At times, the researchers were reliant on professional association newsletters and the distribution of the recruitment email from the association itself. Recruitment was conducted over approximately 3 months. Results were analyzed using Microsoft Excel software, and text answers were reviewed for frequencies and themes.

Results

There were 511 initial survey participants with approximately 487 valid survey completions. The provider and practice site types can be viewed in Table 1, and the geographic distribution of participants across North Carolina in Figure 1.

Participant Characteristics

Most participants reported working in a private primary care practice (32.4%); federally qualified health center (FQHC; 20.9%); or "Other" type of facility (17.8%), which were primarily reported as free and charitable clinics or employer-run health centers. There were 260 primary care providers (PCPs; 74.6%) and 61 behavioral health providers (BHPs; 17.6%) in the sample (27 participants reported an "Other" provider type [7.8%], with the most prominent professional group being nurse practitioners [210, 60.3%]). On average, participants had been practicing with their provider credentials in primary care for 11.95 years (SD = 11.29), and specifically in North Carolina for 10.99 years (SD = 10.55).

Experience with Whole-Person Care

When asked if they thought the current health care system in North Carolina was conducive to providing WPC, 21.0% of participants reported yes, 64.5% of participants reported no, and 15.4% of participants reported being unsure. A little over half of the participants reported that their clinic was providing WPC, with 45.7% of participants reporting that their clinic was not. A significant group of participants (66.2%) reported that they were able to provide WPC in their current practice. Most of the participants (76.9%) said that they were more aware of WPC now, compared to when they first started practicing. Though only 40% of participants reported they had received WPC training since leaving graduate school, the remaining participants reported no training or were unsure if they had received training in WPC. See Table 2 for the WPC barriers that participants endorsed.

TABLE 1.
Participant Information about Work Site and Experience

	Frequency (%)
Site	
Federally Qualified Healthcare Center (FQHC)	73 (20.9%)
Community Health Care Center	29 (8.3%)
Rural Health Center	17 (4.9%)
Private Primary Care Practice	113 (32.4%)
Public Health Department	12 (3.4%)
Military Base	2 (.6%)
Veterans Affairs Primary Care	8 (2.3%)
Academic Medical Center	25 (7.2%)
School Based Health Center	8 (2.3%)
Other	62 (17.8%)
Provider Type	
Physician (DO)	5 (1.4%)
Physician (MD)	38 (10.9%)
Nurse Practitioner (NP)	210 (60.3%)
Physician Assistant (PA)	7 (2.0%)
Licensed Marriage and Family Therapist (LMFT)	10 (2.9%)
Licensed Clinical Social Worker (LCSW)	24 (6.9%)
Licensed Professional Counselor (LPC)	7 (2.0%)
Licensed Clinical Addictions Specialist (LCAS)	10 (2.9%)
Psychologist	4 (1.2%)
Associate of aforementioned behavioral health professions	6 (1.7%)
Other	27 (7.8%)

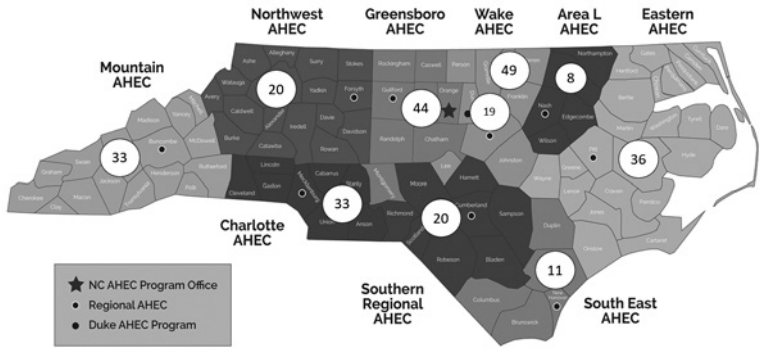
Working with External Behavioral Health Providers

Slightly more than half of the participants (56.4%) reported that they have difficulty communicating with external BHPs, with 48.2% of participants also sharing that they do have a written protocol for how to share information with external BHPs. Fifty-five percent of participants reported that after a referral to an outside BHP is made, their clinic has a protocol to communicate with that provider about the patient's care (e.g., confirming appointment attendance, diagnosis, treatment progress).

Working with Integrated Behavioral Health Providers

Approximately half (56.2%) of participants reported that their clinic has a BHP who sees patients in their clinic, with 74.6% of those participants reporting that their BHP is an employee of their clinic, 11.6% reporting that their BHP works for another agency but works with their patients, and 13.8% of participants were unsure of or had other partnership arrangements with the BHP. Table 3 shows the variety of services that the BHPs provided in participants' clinics, of which there was a somewhat equal distribution of service types from traditionally scheduled appointments to unscheduled same-day appointments. In terms of patient encounters, 14.4% of participants with integrated BHPs reported that their BHP(s) see an average of 0–3 patients per day, 55.3% reported an average of 4–7 per day, 22.7% reported 8–10 per day, and 7.5% reported 11 or more encounters on average per day. Most participants (81%) reported collaboration between PCPs and integrated BHPs happening as in-person consults or electronic health record (EHR) messaging, with fewer participants reporting regular weekly or monthly meetings between PCPs and BHPs. When asked about sustainability, 64.1% of participants reported that they had adjusted their billing practices so that the provision of integrated behavioral health services was a sustainable effort, whereas 35.9% reported that they had not been able to make integrated behavioral health sustainable through billing for services.

FIGURE 1.
Geographic Distribution of Participants by Area Health Education Center (AHEC) Regions



Source: https://www.ncahec.net/about-nc-ahec/find-your-ahec/

Psychiatric Medication Management in Primary Care

Over half of the participants (57.9%) reported having access to a psychiatric consultant. On prescribing psychiatric medications, 74.5% of participants reported that the PCPs in their clinic are frequently or very frequently comfortable prescribing medication for mild to moderate behavioral health conditions. For severe behavioral health conditions, 67% reported that PCPs in their clinic are rarely or never comfortable prescribing medication when needed. Most of the participants (63.2%) reported that their clinic was not capable of handling behavioral health crises.

Discussion

North Carolina is in the midst of a paradigm change to whole-person care (WPC). Survey results indicated that there are different perceptions of the ability to provide WPC between the system, clinic, and provider levels. These discrepancies somewhat mirror the 3-world view of clinical, financial, and operational systems. However, there is still much work to be done.

At the clinical level, over half of the respondents noted that they provide WPC to their patients despite also reporting obstacles and challenges at the financial and operational levels. One example of a reported obstacle that remains is the amount of time providers are given to critically evaluate and improve the implementation of new programs like behavioral health integration. Researchers in the field of implementation science have determined that administrative time set aside to pursue and evaluate new programs overtly is critical to the success of the program; however, over 70% of providers responded that their work environment only occasionally provides meeting time dedicated to the implementation of WPC. Additionally, there are obstacles outside of the walls and policies of the clinic, with approximately 36% of respondents reporting difficulty sustaining whole-person services through billing practices. The results of the survey indicate that the provision of WPC is often provider-dependent due to these and other potential obstacles at the operational and financial levels. When a new program, such as integrated behavioral health care, is implemented in a clinic, there is often variability at the provider level in skill, comfort, and buy-in to the change in service provision. For example, concerning skill set, the study highlighted the minimal training for the workforce on WPC both in graduate schools and by clinics. While the provider is a critical and obvious part of the health care system and delivery of WPC, additional financial and organizational support should be in place to ensure the full degree of implementation in clinics across the state.

The need for WPC has only increased during the COVID-19 pandemic, with 43% of adults reporting in 2021 that the pandemic has had a serious impact on their mental health, up from 37% in 2020, with primary care being the number 1 place individuals seek mental health support [26]. Greater access to providers who are trained in providing WPC can increase the number of patients served and decrease pressure on specialty mental health clinics while also addressing other health conditions. Additionally, these providers need the full support of the broader health care system regarding reimbursement and full organizational and administra-

TABLE 2.
Barriers Experienced in Providing Whole Person Care

Barrier	Frequency (%)
Administrative burden of changing or expanding services	133 (18.1%)
Billing, coding, and reimbursement concerns	138 (18.8%)
Start-up costs for hiring a new behavioral health provider	87 (11.9%)
Difficulty recruiting staff/providers with whole-person care knowledge	88 (12.0%)
Difficulty recruiting behavioral health providers	84 (11.4%)
Difficulty retaining staff/providers	96 (13.1%)
Space concerns for additional staff	108 (14.7%)

TABLE 3.
Services Provided by the Behavioral Health Providers (BHPs)

Service type	Frequency (%)
Scheduled hour-long appointments	94 (24.9%)
Scheduled brief (30-min or less) appointments	109 (28.8%)
Unscheduled brief consult/introductions before, during, or after the patient's PCP visit	100 (26.5%)
Unscheduled same-day appointments	75 (19.8%)

Note. PCP (Primary Care Provider)

tive support in their clinic systems. There is not a population in North Carolina that has gone untouched by the whole-person impact of COVID-19. The widespread availability of sustainable WPC will be necessary to meet the needs of all North Carolinians.

Limitations

The sample was more representative of nurse practitioners (60.3%) than other primary care disciplines (MD, DO, PA were 14.5% combined). Behavioral health providers (LCSW, LPC/LCMHC/LMFT, and associate-level counterparts) made up a smaller portion of the sample than anticipated (24.7%). Information gathered in most of this survey may be more representative of training received by nurse practitioners, rather than of a paradigm shift in the delivery of care. Nurse practitioners can serve a wide variety of roles in primary care, and by definition, the nursing profession has been rooted in treating patients with a biopsychosocial perspective [27]. Additionally, the views captured in this survey were limited to providers, but it would be worth including or focusing on additional members of the clinical practice team in future work. While there was some representation in each AHEC geographic region, there may be unique barriers unrepresented in regions with fewer respondents. Additionally, we did not study how payer types influence the provision of WPC, but this would be worth considering in future work.

Conclusion

Over the past 10 years, the practice of whole-person integrated care has had a wide range of advocates in North Carolina. While the implementation of whole-person care comes with degrees of integration, North Carolina providers have acknowledged its importance for a while despite the often-encountered financial and operational limitations. Of course, providers were limited to providing pieces of whole-person care and subsequently getting limited results; however, Medicaid transformation boosts the potential to change some of these limits. It seems that North Carolina is poised for a paradigm shift in how patients' needs are seen, and as a result, how providers work together with patients and the health system in the health care journey.

FHLI's Center of Excellence for Integrated Care will continue to evaluate and utilize providers' valuable information and insights through this survey project and continue to serve as a voice for integrated behavioral health care. The Center of Excellence for Integrated Care offers an open invitation to collaborate, as well as learn from, all stakeholders, providers, partners, and communities about paving the way for integrated care per its mission "to aid in the clinical, operational and financial transformation of healthcare systems to provide whole person care for all." NCMJ

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