ALASKA BEHAVIORAL HEALTH -PRIMARY CARE SURVEY REPORT RESULTS

Survey Administrator: Division of Behavioral Health
Respondents: Grant Funded Behavioral Health Centers (n=62)
Non-Grant Funded Substance Abuse Treatment Providers (n=6)
Mental Health Physician Clinics (n=1)
Survey Date Range: November 1-30th, 2013
Date of Report: January 6, 2014
Survey Method: Survey Monkey (web-based)
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SURVEY PURPOSE & PROCESS

The survey was conducted for the purpose of assessing state-approved behavioral health providers' current level of service integration with primary care, providing a snapshot of "where we are now" which will assist the Division to identify strategies for moving forward in this area. The electronic survey was a modification of the Doherty Levels of Integration Model[1]. The process for conducting the survey was to e-mail the Survey Monkey link to all provider types and allow a 30 day response window.

BACKGROUND

The integration of behavioral health with primary care has become a growing focus nationally due to the physical health outcomes for individuals with serious behavioral disorders being dramatically worse than those of the average population. Clients with serious behavioral health disorders, on average, have lifespans twenty five years shorter than the general population, largely due to chronic medical conditions such as obesity, diabetes, cardiovascular, and pulmonary disease. In this context, integration of primary and behavioral health care has become vital.

There is positive and promising movement towards integration around our state particularly with those behavioral health agencies who have co-located with a Federally Qualified Health Center. We understand that not all agencies are able to develop an on-site medical health capability but many agencies have developed working relationships with community health centers or primary care providers. This survey explores those relationships.

SUMMARY OF DATA

Are you currently collaborating with a primary care provider? (n=62)

Response	Percent	Number of Responses
No collaboration or occasional	44%	27
Have a documented agreement and some degree of coordination	32%	20
Co-located with Primary Care	24%	15

[1] Doherty, McDaniel, & Baird (October 1996). Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*.

What's your agency's level of integration in regard to ACCESS to primary care? (n=69)

Response	Percent	Number of Responses
Two separate sites	72%	50
Same site – some joint service	15%	10
One site – one record, integrated provider	13%	9

What's your agency's level of Integration in regard to SCREENING/REFERRAL with primary care? (n=69)

Response	Percent	Number of Responses
Separate screening tools with little or no coordination w/ results	64%	44
Separate screening tools results are referred	19%	13
PC/BH both screen, use a single record, results available to both	17%	12

What's your level of integration in regard to SERVICES? (n=69)

Response	Percent	Number of Responses
Separate services no sharing of treatment plans	39%	27
Separate services occasional or regular sharing of tx plans	58%	40
Integrated services one tx plan	3%	2

Does the clinic have policies and procedures regarding referrals to primary care? (n=63)

Response	Percent	Number of Responses
Yes	71%	45
No	29%	18

What's the level of integration in regard to FUNDING? (n=69)

Response	Percent	Number of Responses
Separate systems and funding, No sharing of resources	61%	42
Separate funding with some sharing of expense	23%	16
Separate funding but substantial sharing of expense (staff, facility)	9%	6
Integrated funding, resources shared across needs	7%	5

What's the level of integration of GOVERNANCE between PC/BH? (n=69)

Response	Percent	Number of Responses
Separate systems with little or no collaboration	51%	35
Two boards work with varying degrees of collaboration	24.5%	17
One board with equal collaboration	24.5%	17

What's your level of integration in regard to HEALTH CARE RECORDS? (n=69)

Response	Percent	Number of Responses
Separate systems	38%	26
Separate systems but some sharing of information	55%	37
One health care record	9%	6

What's the integration in regard to DATA? (n=69)

Response	Percent	Number of Responses
Little or no sharing of data	39%	27
Separate data, some collaboration on individual cases	46%	32
Separate data, some aggregate data sharing on population groups	9%	6
Fully integrated data from one source	6%	4

Does your agency have an electronic record? (n=68)

Response	Percent	Number of Responses
Yes	66%	45
No	34%	23

If a referral is made from primary care to behavioral health the client is: (n=69)

Response	Percent	Number of Responses
Generally scheduled at a later date	49%	34
Introduced to the BH provider, then generally scheduled at a later date	38%	26
Generally seen that day	13%	9

Behavioral treatment plans and approaches are: (n=65)

Response	Percent	Number of Responses
Primarily reached by PC physician	0%	0
Primarily reached by BH provider	80%	52
Reached with input from both	20%	13

The clinic currently holds groups or education for recipients on: (n=57)

Response	Percent	Number of Responses
Addictions, substance abuse	77%	44
Depression, PTSD, MH issues	72%	41
Trauma	53%	30
Self-empowerment	49%	26
Smoking Cessation	35%	20
Exercise	35%	20
Nutrition	31%	18
Pain Management	14%	6

Does the clinic hold joint training for both PC and BH staff on these topics? (n= 54)

Response	Percent	Number of Responses
Addictions, substance abuse	26%	14
Depression, PTSD, MH issues	30%	16
Trauma	26%	14
Self-empowerment	13%	7
Smoking Cessation	9%	5
Exercise	5%	3
Nutrition	13%	7
Pain Management	11%	6
No Joint Training	57%	31

Barriers encountered in integrating with primary care?

Funding	• Lack of funding for development of new or expanded initiatives • Inability to bill third-party (insurance) for integrative services. • Lack of funds to support a clinician housed in the primary care location or having a primary care provider on contract. **For Clients** • As most of our (substance abuse tx) clients do not have insurance and are not eligible for Medicaid, they have few or no options among private providers of primary care.
Multiple Primary Care Providers	• All clients…. have the right to choose their own providers so we would have to integrate with several providers and the providers may change based on client and guardian preference.

Limited Time/ Limited Capacity	• There is a lack of time for administration to thoroughly work with PCP personnel to establish good working connections. • The physicians are generally unavailable to meet or discuss cases. • In a rural area services of both types are limited and tend to be at or over capacity.
Resistance	• We need Primary Care providers who are willing to work with Behavioral Health problems and who are willing to collaborate with drug treatment providers. • Other PC providers have not yet been interested in more formal arrangements. • Resistance from BH providers because they feel everything they do should be private. • Clients resistant – stigma of behavioral health services.
Confidentiality	• I feel it's VITAL to discuss CFR 42 Part 2 confidentiality issues. • Confidentiality - both have separate regulations and primary care agencies are not aware of the strict federal confidentiality regulations for Alcohol and Drug records/programs. • Substance Abuse Confidentiality rules (42 CFR) affects our ability to have integrated systems.
Need for Education	• Need technical assistance regarding available models, costs, ability to bill etc. • Hiring clinicians that can work in primary care -both clinicians that are comfortable in primary care & have the training and skill set. • Lack of (primary care provider) knowledge or appreciation of concerns relating to areas such as FAS, substance abuse and trauma arises. • Primary physicians to educate our staff as needed on medical concerns that consumers may have.
Space Limitations	• No space in either the primary care clinic or the behavioral health clinic to co-locate • Size of facility. We want to co-locate but not enough space in our clinics. • Space limitations in the primary care facility.
Communication Issues	• Follow-up treatment timely response severely lacking in most cases regarding asking for collateral information. • Lack of mutual understanding and agreement of treatment goals and priorities
Electronic Health Records Problems	• Behavioral health systems do not do primary care at all; medical EHRs don't do behavioral health well. Major issues with the oddities of data definitions, demands and processes of AKAIMS as compared to UDS • One EHR emphasizes one program over the other, the cost of changing to one EHR, • AKAIMS required by DBH but has no utility for PC.

State Level Issues	• Procedures and policies at a State level • Also the detailed requirements of BH assessment and tx planning do not flow well with the much less strict physician standard. Detail required in treatment planning before service is substantial barrier to care. • Medicaid requirements for assessments and treatment planning are an obstacle for consumers seen in or at a primary care setting.

OTHER SUGGESTIONS/ COMMENTS FROM PROVIDERS

- Create a model where shared services are encouraged and additional funding can be attained through demonstrated daily collaborative actions and innovations.
- Different companies have different needs and one model might not meet the needs of all companies especially when not all clients have the funding to pay for primary care.
- It would be very helpful if more formal conversations could occur between the DBH and AK Primary Care Assn. to gain a commitment to work with BH providers toward the common goal of integration in a manner that works best in their communities and with their specific populations. Many do not see the benefit to doing this yet.
- Please review SAMHSA Integrative Health Website and "turn-on" billing codes for integrative services,
- Allow Case Management services to be billable during time spent with a primary care provider when accompanying a consumer.
- Passing of the Federal Behavioral Health Centers (legislation) would help.
- Many clients (e.g. SMI, SED, SUD) do not fit easily into the primary care model

NEXT STEPS FOR DBH

- The Division of Behavioral Health, in conjunction with the Department of Health and Social Services intends to work collaboratively with the Alaska Primary Care Association and the Alaska Mental Health Trust to identify strategies for addressing barriers to integration and explore new initiatives in this area.

  Thank you to all who participated in this survey.