

Primary Care and Behavioral Health Integration

A Briefing Paper for Medicaid Redesign Workgroups

Created by an internal workgroup from the Divisions of Behavioral Health and Public Health:

James McLaughlin
Susan Mason-Bouterse
Jimael Johnson
Michael Powell

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Introduction

The Department of Health and Social Services has identified Primary Care-Behavioral Health Integration as a priority objective.¹ The Medicaid Redesign process offers an opportunity for the state to evaluate and address the barriers to integrated care as part of the larger effort to develop a systematic and cost-effective approach to patient-centered care. A workgroup consisting of staff from the Divisions of Behavioral Health and Public Health collaborated in the development of this briefing paper on integration. In our review of integration efforts around the state, we have found that many organizations are working to integrate primary and behavioral health care but are encountering a similar set of barriers and challenges. This briefing paper seeks to inform the Medicaid Redesign efforts by:

- Presenting a case for integration;
- Identifying specific barriers to integrated care and providing recommendations to help move toward a more integrated system of care;
- Giving examples of integration efforts in Alaska;
- Sharing a “drill-down” of common aspects of a few of Alaska’s current integrated care systems.

Part I: A Case for Integrated Services

There is pervasive evidence of the need for primary care and behavioral health providers to work closely together. Depression is the third most frequent condition seen by primary care providers.² Seventy-nine percent of all antidepressant medication is prescribed by primary care providers.³ Persons with a comorbid mental health/substance use disorder constitute one of Medicaid’s highest cost beneficiary populations with health care costs 2-3 times those of beneficiaries without a comorbid disorder.^{4,5} Even with these higher health care costs, persons with severe mental illness have average lifespans 14-32 years shorter than the general population due to chronic health problems such as high blood pressure, smoking, heart disease, diabetes, obesity, and asthma.⁶

¹ <http://dhss.alaska.gov/Documents/Publications/priorities.PDF>

² Ornstein et al., Journal of the American Board of Family Medicine, 2013 Sept. 518-524

³ Mark T. et al., Psychiatric Services, 2009 Sept. 60:1167

⁴ Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, Inc. 2014 April

⁵ Kaiser Foundation, 2014. <http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/>

⁶ Colton and Manderscheid. Preventing Chronic Disease 2006 Apr.

Multiple studies have shown decreased costs in primary care when behavioral health treatment is offered, with depression treatment resulting in a return of \$6.50 for every \$1 spent.⁷ Tennessee, Vermont, Massachusetts, and Colorado have developed statewide models for robust systems of integrated care and are seeing improvements in quality of care and decreased costs. Approaches to providing integrated care can consist of both behavioral health provided in primary care settings and primary care provided in behavioral health settings. In the absence of full integration through on-site services, effective collaboration between a behavioral health and primary care provider is an alternative model for integrated or “whole health” care.

Part II: Specific Barriers and Recommended Solutions

Barrier 1: There is not a statewide strategy for integrated care.

Recommendations:

- A. Solicit input from external stakeholders on how best to promote primary care and behavioral health integration and establish and maintain strong working linkages between primary care and behavioral health providers. Suggested key participants include the Alaska Primary Care Association, the Alaska Behavioral Health Association, Alaska Native Tribal Health Consortium, primary care providers, behavioral health providers, and community-based prevention and wellness coalitions;
- B. Develop a statewide strategy for integrated care that supports and encourages innovation of new and effective, evidence-based models;
- C. Ensure the Medicaid Redesign Workgroups focusing on Primary Care Initiative, Coordinated Care Organization Demonstration, Behavioral Health Systems Reform and Telemedicine include the integration of primary care and behavioral health in their work;
- D. Increase the involvement of the Division of Public Health in the workgroups listed above to ensure strategies include a population health focus;
- E. Assure integration is addressed and informs the Behavioral Health Redesign and Reform Initiative including the 1115 waiver application process.

⁷ Jones & Macias: Psychiatric Services 2004: 55: 1250-1257.

Barrier 2: There is a significant and worsening lack of capacity in Alaska’s primary care and behavioral health workforce.

Recommendations:

- A. Address professional licensure barriers that impede new providers becoming licensed in Alaska such as delays in licensure reviews;
- B. Support funding of student loan repayment programs such as SHARP, the State’s loan repayment program;
- C. Support emerging professions such as the community health worker apprenticeship program and peer counselors;
- D. Increase retention through strategies to reduce clinician isolation such as promoting professional support networks.

Barrier 3: Primary care providers are often hard pressed to identify and/or address behavioral health issues in the course of a 10-15 minute appointment. The detection and management of mental health or substance abuse problems competes with many other priorities, such as treating acute physical illness and monitoring chronic conditions.

Recommendations:

- A. Allow for and encourage behavioral health care in primary care settings, particularly for individuals with mild or moderate behavioral health problems. Encourage and support primary care models using team-based care that incorporates behavioral health providers and allows for “warm hand-offs” for behavioral health care.⁸ Allow for and encourage the use of care managers/coordinators who can assist with referrals/appointments when clients must be referred out;
- B. Promote and standardize the screening and treatment of behavioral health disorders in primary care settings.

⁸ “An approach in which the primary care provider does a face-to-face introduction of a patient to the behavioral health specialist to which he or she is being referred.” <http://www.integration.samhsa.gov/glossary>

Barrier 4: Primary care providers are, in most situations, not set up to provide the counseling, regular patient follow-up, and monitoring of treatment adherence essential for effective diagnosis and treatment of a serious behavioral health disorder. In addition, individuals with a serious behavioral health disorder often are not seen in primary care settings because they can present significant challenges to already busy practices due to lack of insurance, potentially disruptive behavior, and complex treatment challenges.

Recommendation:

- A. Promote formal collaborative relationships between primary care and behavioral health care organizations to allow for efficient bi-directional referral of patients⁹. Formal agreements should address areas such as eligibility, lines of communication, and sharing of confidential information;
- B. Promote the establishment of Behavioral Health Homes where physical health care can be provided in a behavioral health setting.

Barrier 5: For patients with severe mental health and substance use issues who are seen in a primary care setting, a referral to a specialty provider is generally indicated. However, referrals from primary care providers are frequently unsuccessful. Two-thirds of primary care physicians reported not being able to access outpatient behavioral health care for their patients, primarily due to shortages of mental health care providers.¹⁰ When they are able to successfully refer patients to behavioral health, 30-50% of those referred from primary care do not keep their first appointment.¹¹

Recommendations:

- A. Address capacity and access issues with community behavioral health programs that provide wrap-around services for severely mentally ill individuals;
- B. Increase priority access into specialty behavioral health services for patients with serious behavioral health conditions who are referred by primary care providers;
- C. Encourage and support enhanced staffing at primary care clinics to include care coordinators who can assist patients in navigating complex systems;
- D. Increase training, resources and support for primary care providers to refer complex behavioral health clients to specialty behavioral health providers.

⁹ [HRSA SAMHSA Integration Website](#)

¹⁰ Schulberg et al. Arch Gen Psych. 1996; 913-919

¹¹ Cunningham, Health Affairs. 2009; 3w490-w501

Barrier 6: Primary care providers have limited ability to bill Medicaid for behavioral health services. A behavioral health provider in a primary care office cannot bill Medicaid for behavioral health services. The exception is Federally Qualified Health Centers where only Licensed Clinical Social Workers and Licensed Clinical Psychologists are able to bill Medicaid.

Recommendations:

- A. Expand the types of providers who can bill Medicaid for behavioral health services. Further detailed suggestions follow:
- i. Increase the number of primary care practices able to bill Behavioral Health Medicaid. Change Medicaid regulatory requirements for physician oversight in a Physician Mental Health Clinic from a psychiatrist to either a psychiatrist OR a physician;
 - ii. Remove Medicaid physician regulation requirement mandating that behavioral health services be provided directly by the physician and allow licensed behavioral health professionals to “practice under direction of the physician”;
 - iii. Allow behavioral health practitioners to practice and bill Medicaid for services under the direction of an Advanced Nurse Practitioner;
 - iv. Amend the State Plan to add licensed professional counselors, licensed marriage and family therapists, and licensed psychological associates as billable independent Medicaid providers;
 - v. Amend the State Plan to revise coverage in Federally Qualified Health Centers to include the provider types listed in “iv” above.

Barrier 7: There is neither a focus nor a priority in behavioral health settings on managing physical health conditions.

Recommendations:

- A. Establish methods of reimbursement for primary care services in behavioral health programs;
- B. Promote and standardize the screening and monitoring of chronic medical conditions in behavioral health settings;
- C. Develop pilot programs that utilize mid-level primary care providers (nurse practitioners or physician assistants) within a behavioral health clinic such as a Behavioral Health Home;

- D. Develop training/technical assistance opportunities (i.e. billing and coding) for behavioral health practices seeking to add medical services/screening to their scope of practice.

Barrier 8: There is a lack of “best practices” for integrated care in Alaska.

Recommendations:

- A. Identify and promote best practices. For example, standardize when possible the screening and treatment of behavioral health disorders in primary care and the screening and monitoring of medical conditions in behavioral health settings;
- B. Establish a systematic and on-going process to analyze integrated practice claims data for insight into effective models. Utilize results to support quality improvement and systems integration efforts.

Barrier 9: Sharing health information across systems is challenging.

Recommendations:

- A. Establish communication and coordination strategies between primary health care and behavioral health providers to support sharing of information on mutual clients. Address different requirements for patient confidentiality, revise regulations or statutes as needed, and support providers’ ability to share relevant treatment information with each other;
- B. Establish a cross-disciplinary forum to identify solutions for integrated Electronic Health Record systems;
- C. Address the absence of a fully developed and integrated Health Information Exchange capable of providing practices with population health data for evaluating efficacy of care.

Part III: Integration Efforts in Alaska

Efforts in Alaska to integrate primary and behavioral health care include:

- **Federally Qualified Health Centers**

Federally Qualified Health Centers (FQHCs) are expected to provide some level of behavioral health service and can be reimbursed for Licensed Clinical Psychologist and Licensed Clinical Social Worker services, as well as psychiatric services. Many of the 29 Health Resources Services Administration-funded FQHCs in Alaska, with services in 159

communities, employ Licensed Clinical Social Workers or Licensed Clinical Psychologists and some provide psychiatric services.

- **Independent Primary Care Providers**

Several non-FQHC primary care providers provide behavioral health services, primarily medication management. A number of non-FQHCs have hired behavioral health providers but are unable to obtain Medicaid reimbursement for their services.

- **Substance Abuse and Mental Health Services Administration’s Primary and Behavioral Health Care Integration Grantees**

Primary and Behavioral Health Care Integration grants develop primary care capacity in existing behavioral health treatment settings. Grantees in Alaska have included:

- Alaska Island Community Services (awarded 2010-2014)
- Southcentral Foundation (awarded 2011-2015)
- Juneau Alliance for Mental Health, Inc. (awarded 2015-Present).

- **Alaska Patient Centered Medical Home Initiative (Alaska Primary Care Association & Department of Health & Social Services, 2011-present)**

Patient Centered Medical Home (PCMH) is a recognition process for primary care practices that defines and requires five broad functions and attributes. Practices receiving PCMH recognition demonstrate comprehensive, patient-centered, coordinated care; accessible services, and a commitment to quality and safety. Inherent within PCMH recognition is the provision of integrated primary and behavioral health care. Currently twenty-five Alaska practices have national PCMH recognition. The department awarded a 2011 grant to the Alaska Primary Care Association to implement the Alaska Patient Centered Medical Home Initiative to support technical assistance and training for several primary care practices over a period of several years to increase the number of PCMH recognized practices in Alaska. Participating practices included:

- Alaska Center for Pediatrics – National Committee for Quality Assurance (Level 3)
- Peninsula Community Health Services – National Committee for Quality Assurance (Level 1)
- Mat-Su Health Services – National Committee for Quality Assurance (Level 2)
- Homer Medical Clinic – application submitted in June 2016 – pending determination
- Seldovia Village Tribes - will be submitting application in December 2016

- **Pediatric Medical Home and Systems Integration Programs (Division of Public Health/Section of Women, Children, and Family Health, 2011-present)**

The Pediatric Medical Home Program works to integrate systems of care for children and youth with special health care needs through the following activities:

- Assess pediatric systems to identify gaps and priorities;
 - Develop a “shared resource” for families and providers using the “Help Me Grow” centralized system model;
 - Expand provider access to medical home concepts and tools through education and statewide technical assistance;
 - Expand care coordination training program developed in partnership with the University of Alaska and the All Alaska Pediatric Partnership;
 - Integrate and adopt quality improvement measures and associated statewide medical home policy level initiatives.
- **IMPACT and SBIRT Programs**
The Alaska Mental Health Trust Authority provided pilot funding to three agencies (Anchorage Neighborhood Health Center, Chugachmiut and Southeast Alaska Regional Health Consortium) to support implementation of two best practice models of screening and treatment: “Improving Mood – Promoting Access to Collaborative Treatment “(IMPACT) and Screening Brief Intervention and Referral to Treatment (SBIRT). In 2013, Mat-Su Health Services also received a 3-year IMPACT grant from the John A. Hartford Foundation and the Rasmuson Foundation.
- **Tri-State Children’s Health Improvement Consortium (Division of Public Health/Health Planning and Systems Development, 2011-2015)**
This consortium was a three-state (Alaska, Oregon, and West Virginia) Centers for Medicare and Medicaid Services medical home demonstration project to improve children’s health and health care quality measurement, integrate Health Information Technology systems, and develop the best models of health care delivery for children and adolescents enrolled in Medicaid and Denali Kid Care. A key outcome of this project in Alaska has been the implementation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience of care survey (see bullet below).
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) (Health Care Services/Division of Public Health/Health Planning and Systems Development/Women, Children, and Family Health, 2012-present)**
The CAHPS “Patient Centered Medical Home Clinician and Group Patient Experience Survey” has been fielded annually in Alaska practices and statewide with Medicaid recipients since 2012. The survey was originally designed specifically for the Tri-State Children’s Health Improvement Consortium project (Alaska, Oregon and West Virginia) and includes a module to identify children with special health care needs. Although the tri-state project formally ended in 2015, Denali KidCare and Title V continue to implement the

survey to monitor, plan, and inform quality improvement activities. Participating practices have included: Peninsula Community Health Services, Alaska Center for Pediatrics, Sunshine Community Health Center, South Central Foundation, Iliuliuk Family & Health Services, Mat-Su Health Services, Homer Medical Center, and LaTouche Pediatrics.

- **All Alaska Partnership Project (Division of Behavioral Health, 2014-2018)**

The Division of Behavioral Health is in the fourth year of a federal Center for Substance Abuse Treatment grant (the Partnership to Improve Outcomes for Adolescents and Families) to improve substance abuse treatment for transition aged youth and young adults. Key elements of the project include implementing evidence-based practices, expanding access to services, and ensuring that services are coordinated across systems. To accomplish these goals, the Division of Behavioral Health created a cross-agency “Project Advisory Council” to provide cross system feedback and oversight into project implementation including: use of evidence-based practices; financial mapping/leveraging resources; identifying gaps, barriers and strategies to improve access to treatment; and linking youth to collateral services and supports to improve outcomes.

- **Alaska Project AWARE (Department of Education & Early Development, 2015-2019)**

The Department of Education & Early Development is in the second year of a federal Substance Abuse and Mental Health Services Administration grant to improve school safety by addressing mental health issues in school-aged youth through Alaska’s Project AWARE. The Department of Education created a statewide management team comprised of multiple state agencies and three schools districts to accomplish project goals. Through local and state partnerships, the grant builds school capacity to address mental health in a more coordinated and integrated fashion; provides training for early detection and response to mental health issues; connects youth and families with mental health services; and implements effective ways to promote behavioral health and prevent mental illness.

- **Certified Community Behavioral Health Clinic Planning Grant**

The Division of Behavioral Health supported two community behavioral health agencies (Anchorage Community Mental Health Services and Peninsula Community Health Services) in a planning process to become certified behavioral health clinics. An element of certification includes providing primary care screening and monitoring in a behavioral health clinic. Although the state will not be going forward into the two-year demonstration project, the planning has provided valuable information relative to primary care-behavioral health integration.

- **Co-located Community Behavioral Health and Primary Care**

The Division of Behavioral Health conducted a 2013 survey of their grantees that explored collaboration and integration with primary care. Fifteen of sixty-two responding grantees indicated they were co-located with a primary care practice. Twenty other agencies reported some level of formal collaboration with primary care.

Part IV: Interviews with Alaska Organizations Providing Integrated Care

For purposes of this briefing paper, and in order to establish a baseline, workgroup members conducted structured interviews with nine Alaskan organizations currently providing integrated care. Workgroup members conducted seven in-person interviews and two phone interviews. Organizations were receptive and very engaged in the process. Organizations interviewed were a convenience sample and are not the only sites offering integrated care in Alaska. One interview question asked respondents to classify the level of integration of their organization based on the concept of five levels of integration.¹² (*See description of five levels of care in Addendum*). Six organizations rated their level of integration as 4 or greater. The remainder rated as 3 to 3.5.

The majority of organizations were implementing a model of integrated care that involved a behavioral health consultant working as a member of the primary care team, accepting “warm hand-offs” from primary care providers and providing varying levels of “curb-side consultation” to the primary care providers who were seeing patients with behavioral health issues. Of note, organizations such as Eastern Aleutian Tribes are using a combination of on-site behavioral health consultants and telemedicine to integrate care. The ratios of behavioral health consultants to primary care providers varied considerably; many of the sites had vacant behavioral health consultant positions and had been actively recruiting for long periods of time. Extended recruitment periods reflect the shortage of Medicaid-billable providers willing to work in remote or rural communities.

Integrated care has been provided in Alaska for over twenty-five years by multiple types of organizations, in rural and urban areas, and despite considerable barriers and challenges.

Two organizations reported beginning integrated care as early as 1991 while three organizations reported starting between 2012 and 2016. The remainder of the sites were scattered between the time period of 2001 and 2007.

¹² [Evolving Models of Behavioral Health Integration in Primary Care](#), Collins, Hewson, Munger, Wade, p.14, 2010.

More than one site listed provider frustration due to the difficulty of ensuring behavioral health access for their patients as one of the contributing factors driving them to integrate care. Several sites reported that they chose to begin providing integrated care because of patient need and difficulty in accessing behavioral health care for their patients. One organization identified behavioral health integration into the primary care setting as a prevention strategy which they anticipated would reduce the need and number of referrals to more intensive services. Some organizations noted they could see that integrated care was part of the future of health care, thus they were making a strategic decision both for their patients and for their organization. Factors influencing organizations to integrate care varied according to the type of site, particularly since sites recognized as PCMH and FQHCs are required to provide integrated care. Tribal organizations in rural and remote areas often are providing integrated or co-located care out of necessity.

Sites use a variety of electronic health records and reported a spectrum of success and barriers regarding integrated records. Some electronic health records such as Centricity allow for integrated care and use permissions effectively to ensure confidentiality of records. However, other systems do not offer such seamless platforms, particularly when organizations work with separate record systems for behavioral health and primary care.

Four sites reported varying levels of difficulty ensuring sustainability. Private practices that do not receive federal funding report particular difficulty due to their inability to bill Medicaid for behavioral health services. Most sites bill for behavioral health services, though most encounter challenges with Medicaid reimbursement. Several sites have federal Health Resources Services Administration grant funds to support integrated care. Six sites reported that integrated services are sustainable (as supported by federal funding), though even those six express concern over the difficulties experienced in obtaining Medicaid reimbursement for integrated care.

Sites reported **numerous barriers and challenges to providing integrated care**, including:

- Recruitment and retention of qualified workforce, in particular behavioral health providers who are able to work effectively in this emerging model that is not commonly covered in most traditional professional education;
- Duplicative documentation requirements such as electronic health records and AK AIMS, the Division of Behavioral Health's management information system;
- State funding cuts resulting in decreased administrative staff;
- Medicaid billing restrictions on provider types for behavioral health billing;

- Disparate cultures of primary care and behavioral health creating challenges in providing effective integrated care.

When asked what types of assistance sites needed, **most sites responded that funding assistance would be most helpful, and the majority requested changes in Medicaid billing requirements to allow for additional behavioral health provider types.** Other responses varied from ensuring access to psychiatric care to creating list-serves for organizations providing integrated care, allowing for sharing of best practices and creation of benchmarks to measure progress. Some sites requested technical assistance on doing medical billing; others listed increased loan repayment programs and finding ways to expedite the licensure process.

Clinics Interviewed:

Sunshine Community Health Center
Crossroad Health Systems
Interior Community Health Services
Anchorage Neighborhood Health Services
Eastern Aleutian Tribes

Southcentral Foundation
Peninsula Community Health
Juneau Alliance for Mental Health
Solstice Family Health Care

A detailed compilation of findings from the interviews will be available upon request after October 15, 2016. Contact Susan.Mason-Bouterse@alaska.gov for more information.

Addendum

Levels of Integration

(Evolving Models of Behavioral Health Integration in Primary Care, 2010, Page 14)

LEVEL 1: Minimal collaboration. Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.

LEVEL 2: Basic collaboration at a distance. Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems.

LEVEL 3: Basic collaboration on-site. Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.

LEVEL 4: Close collaboration in a partly integrated system. Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.

LEVEL 5: Close collaboration in a fully integrated system. The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care.