Improving Access to Behavioral Health Care for Children, Adolescents, and Families: Solutions for Advancing Behavioral Health Integration at Primary Care Practices in Oregon

Background

The evidence for integrating behavioral health[1] and primary care services is clear. Both nationally and in Oregon the policy direction to integrate behavioral and physical health has already been set. Now is the time to move past historical silos, mental health carve outs, pilot projects, and piecemeal grant funding. Oregon's health system transformation touts the integration of physical and behavioral health, but there are many barriers that stand in the way of realizing that goal. In addition, because the vast majority of primary care practices care for both public and privately insured patients, we must ensure parity so that all Oregonians can access integrated behavioral health services if offered to them**.** While many primary care practices in Oregon have begun providing integrated health care[2] because the need is evident and it's the right thing to do for patients and families, these efforts are **not sustainable and will not expand** without fundamental system-level changes.

This issue brief is the culmination of a diverse multi-stakeholder expert workgroup (see Appendix A) that convened eight times from January 2015 – March 2016. The workgroup participants recognize that there are substantial barriers to integrating behavioral health care in primary care practices, but **solutions are attainable** through our collective voice, advocacy efforts, and systems collaboration. The recommended solutions in this issue brief are endorsed by the following organizations (also see Appendix B):

Children's Health Alliance and Foundation
Oregon Pediatric Society
Oregon Academy of Family Physicians
Oregon Association for Behavior Analysis
Tri-County Behavioral Health Providers Association
Oregon Council of Child and Adolescent Psychiatry
Oregon Psychological Association
Western Psychological Services
Oregon Psychiatric Physicians Association
Kartini Clinic

These organizations concur that **the proposed solutions in this brief are necessary** if Oregon is to realize the Triple Aim of health care reform: Improved population health, improved patient and family experience, and controlled total cost of care, not to mention an adequate healthcare workforce.

Audience and Purpose

This brief is intended to provide a unified voice to help remove integration barriers in Oregon, with a specific focus on unique considerations for children, prenatally through adolescence, and their families. One of the most significant needs includes the ability to provide prevention, early intervention, and parent education and support before behavioral health issues reach the level of a

diagnosable disorder – something not possible in the current system. It is also important to recognize that the opportunity for prevention begins prenatally and that integrating behavioral health with maternity care should also be prioritized.

This brief is not intended to describe each integration barrier in-depth, but will focus on actionable solutions including the possible partner organizations that could move forward with implementing the proposed ideas. It is important to note that there may be people and organizations in Oregon already working on the various issues identified in this brief. In some cases the workgroup's proposed solutions may complement and align with work already being done. In no way are they intended to disrupt or duplicate efforts already underway, but instead provide grassroots guidance and creative solutions that specifically address the needs of children, adolescents, and families on behalf of a broad contingency of knowledgeable stakeholders.

Please note that this brief addresses issues germane to the **primary care system**, not to secondary or tertiary mental health care. Workgroup participants wish to emphasize that the secondary and tertiary mental health system may have additional needs, most notably a history of being significantly underfunded, but those are outside the scope of this issue brief.

The target audience for this brief is policy makers at all levels of the legislative branch and government, public and private insurance plans, educational institutions, providers, professional organizations, advocacy groups, and any other stakeholders with an interest in improving children, adolescents, and families' access to integrated behavioral health at primary care practices in Oregon.

Integration Barriers and Proposed Solutions

The expert stakeholder workgroup identified many barriers for primary care practices striving to provide integrated health care, which primarily fall under the following six categories below; barriers 1 – 4 will be addressed in this brief:

1) Financing and Payment
2) Care Coordination and Information Sharing
3) Workforce Concerns
4) Measurement and Accountability
5) Historical Silos and Cultural Differences
6) Lack of Physical Space at Primary Care Practices

The organizations endorsing this brief share a common vision to improve children, adolescents, and families' access to integrated behavioral health care, including access to prevention and early intervention services that will ensure a future of healthy Oregonians.

Financing and Payment

Fragmented financing structures, inconsistent benefit coverage, and low behavioral health payment rates are some of the most formidable barriers to integration. Contracting structures that "carve out" behavioral health benefits to separate organizations often result in restricted access to services, double co-payments and confusion for patients & families, and excessive administrative burden for providers. In addition, current FFS/encounter-based payment mechanisms require a diagnosis, which prevents children, adolescents, & families from accessing team-based preventive care before issues reach the level of a diagnosable behavioral health disorder.

Proposed Solutions to Remove Barriers	Possible Partner Organizations
1) **Reduce Fragmentation by Modernizing Health Plan Contracting Structure**: Eliminate mental health carve out models for primary care practices providing integrated health care, which would reduce administrative burden and facilitate integration by allowing primary care and behavioral health clinicians[3] at the same practice to be included in the same contract and undergo the same credentialing process (See Appendix C for example). Pre-authorizations, double co-pays, and other barriers should also be eliminated.	- May require legislative action - Department of Consumer and Business Services and Oregon Insurance Division - Oregon Health Authority & CCOs - Private and public insurance plans
2) **Ensure Access to Preventive Behavioral Health Care**: All children, adolescents, & families should have access to team-based preventive behavioral health services and parent education & support by requiring that all public and private payers adequately cover a basic package of preventive services via an alternative payment mechanism for integrated patient-centered primary care homes (See Appendix D for recommendations). Payment should include behavioral health services that do not require a "physical" or "mental" health diagnosis; current FFS payment mechanisms require behavioral health issues to be severe enough to have a diagnosable disorder before services are paid by health plans, which limits access to needed preventive care.	
3) **Increase Investments in Early Childhood Behavioral Health Prevention & Early Intervention**: Increase statewide investments in integrated primary care and community-based preventive behavioral health and early childhood social-emotional development programs, including home-visiting programs. It is critical to ensure sustainable payment levels for integrated behavioral health services and to support a skilled, competent, and effective workforce. Coordinate with the work of the Early Learning Hubs.	
4) **Ensure Health Plan Compliance with Existing Laws:** Ensure all public and private health plans comply with existing laws including The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, the ACA requirement to cover and pay for preventive services with no cost sharing to patients/families, and the new 2015 Oregon law allowing integrated behavioral health clinicians to use all billing codes applicable to the behavioral health services they provide (SB832, amended in ORS 414.655).	

Care Coordination and Information Sharing

Some behavioral health and primary care providers/organizations are reluctant to share patient information for care coordination purposes. Historical silos separating behavioral and physical health providers and widely misinterpreted laws (e.g., HIPAA, 42 CFR Part 2) result in fragmented, inefficient care and patient safety concerns.

Proposed Solutions to Remove Barriers	Possible Partner Organizations
1) Create a care coordination/information sharing ombudsman at the Oregon Health Authority to be a single point of contact to mediate and advocate for care coordination and appropriate patient information sharing between health care providers/organizations. Provide legal consultation services so that providers/organizations can access a neutral legal opinion on specific situations.	- Oregon Health Authority - May require legislative action
2) Provide educational opportunities for physical and behavioral health clinicians, health care entities, privacy officers, and in-house legal counsel about information sharing/care coordination expectations, emphasizing what can and should be shared to improve patient care, coordination, and safety (rather than exclusively focusing on what cannot be shared). Education should also include how to have conversations with patients and families about the importance of information sharing to improve safety and coordinate their care.	- Oregon Health Authority & CCOs - Provider Professional Organizations & Licensing Boards
3) Require all privacy officers and in-house legal counsel at public and private health care entities to participate in annual educational activities (as above in #2) to improve information sharing/care coordination across systems.	- May require legislative action
4) Leverage the behavioral health services available in school-based health centers and improve communication and coordination with primary care, recognizing the importance of privacy and confidentiality requirements. Ensure payment and attribution policies incentivize shared population management between primary care and school-based health centers.	- School-based health centers - Oregon Health Authority & CCOs
5) Convene and support an expert panel to develop, pilot, and help spread implementation of a pediatric universal referral/information exchange form to standardize and encourage two-way communication between primary care and community-based behavioral health clinicians. Build on the successful process used for the Early Intervention/Early Childhood Special Education Universal Referral Form.	- Oregon Health Authority - Professional Organizations
6) Ensure that health information exchange technology (i.e. HIE pilots, direct secure messaging, etc.) is inclusive of all types of healthcare providers and health information (physical, behavioral, mental, developmental, substance abuse, school-based health centers, etc.), and includes a mechanism to share care plans with children and their family or caregiver.	- Oregon Health Authority HITOC - Provider Groups - Public & private payers

Workforce Concerns

Oregon has a shortage of behavioral health clinicians specially trained in early childhood social-emotional health, both for referral and to provide integrated behavioral health care. The workforce shortage is compounded by unreasonably low behavioral health payment rates and excessive administrative burden, particularly from commercial plans, which contribute to clinician turnover and an increasing number of behavioral health clinicians that do not accept insurance.

Proposed Solutions to Remove Barriers	Possible Partner Organizations
1) **Train the Transdisciplinary Workforce of the Future:** Move beyond professional education and training silos by developing transdisciplinary team-based training, education, and residency programs to adequately prepare the primary care workforce of the future. Training programs should be encouraged to partner with patient-centered primary care homes as training sites to provide concrete experience. Supervision requirements should be adapted to allow broader participation, and virtual training programs should be further developed.	- OHA Healthcare Workforce Committee - Educational institutions
2) **Increase the Early Childhood Behavioral Health Workforce:** Create and execute a comprehensive strategy to increase the workforce of behavioral health clinicians, particularly those trained in caring for children and their families, prenatally through age eight. The strategy should include funding training programs, student loan repayment for providing early childhood behavioral health services, and opportunities for current behavioral health clinicians to receive ongoing training.	- Oregon Health Policy Board
3) **Reduce Excessive Administrative Burden and Open Commercial Panels:** Develop a strategy to reduce the excessive administrative burden imposed by health plans such as complex benefit coverage and limitations, pre-authorization requirements, and repeated claim denials. Many independent behavioral health clinicians cannot support the overhead to challenge these practices, contributing toward a shortage of clinicians that patients & families can access. In addition, many commercial plans will not open their panels to allow additional behavioral health clinicians, which limits access to those specially trained in the unique needs of children & families. Oversight is needed to ensure access to behavioral health services is measured from the patient and family perspective, particularly as narrow insurance networks proliferate.	- Oregon Insurance Division - Oregon Health Policy Board
4) **Increase Access to Telehealth and Behavioral Health Consultation Services:** Ensure adequate insurance coverage and payment for telehealth services for patients and families, and also ensure that primary care clinicians can access behavioral health consultation to support cost-effective and accessible behavioral health care in primary care settings.	- Oregon Health Authority & CCOs

Measurement and Accountability

Currently Oregon has no way to assess how many primary care practices provide integrated behavioral health care or true access of available behavioral/mental health services. In addition, there is no widely-accepted way to measure the impact of integration efforts or what accountability measures should be used under value-based contracting structures, which would help support better coordinated care and facilitate movement away from FFS/encounter-based payment.

Proposed Solutions to Remove Barriers	Possible Partner Organizations
1) **Understand Current Level and Set a Benchmark for Integrated Health Care in Oregon** – Measure and set a benchmark for how many patient-centered primary care homes provide integrated health care, based on the recommended minimum criteria adopted by CCO Oregon and the Integrated Behavioral Health Alliance of Oregon (IBHAO).	- OHA PCPCH Program - Oregon Health Policy Board - OHA Workforce Committee
2) **Convene an Expert Committee to Develop Standardized Accountability/Quality Measures for Integrated Health Care -** A multi-stakeholder expert committee could recommend a concise set of accountability measures appropriate for the scope of practice and site of care, recognizing the unique needs of children/adolescents through an applicable menu-set of measures. A concise, standardized set of measures would reduce administrative burden and complexity. Categories should include ***utilization*** measures that take into account system-wide utilization and cost-savings including secondary and tertiary care, ***patient and family experience of care***, and population-based ***wellness/quality of life outcome*** measures. It is critical to ensure the patient and family voice is heard and valued, and that measures are not narrowly focused on individual clinical outcomes or claims-based measures. If new tools or surveys are recommended, support for implementation through practice-level training and adequate reimbursement by all health plans is necessary.	- Integrated Behavioral Health Alliance of Oregon - Oregon Health Policy Board - Oregon Health Authority & CCOs - Oregon Insurance Division
3) **Clarify and Standardize Documentation Requirements** – Patient-centered primary care homes providing integrated health care should not be required to use the MOTS (Measurement & Outcomes Tracking System), which is designed for specialty mental health centers serving people with more serious mental health conditions. Clarification and statewide standardization would help avoid excessive documentation burden for primary care practices.	- Oregon Health Authority - CCOs

Appendix A: Behavioral Health Integration Solutions Workgroup Participants

Expert Contributors:
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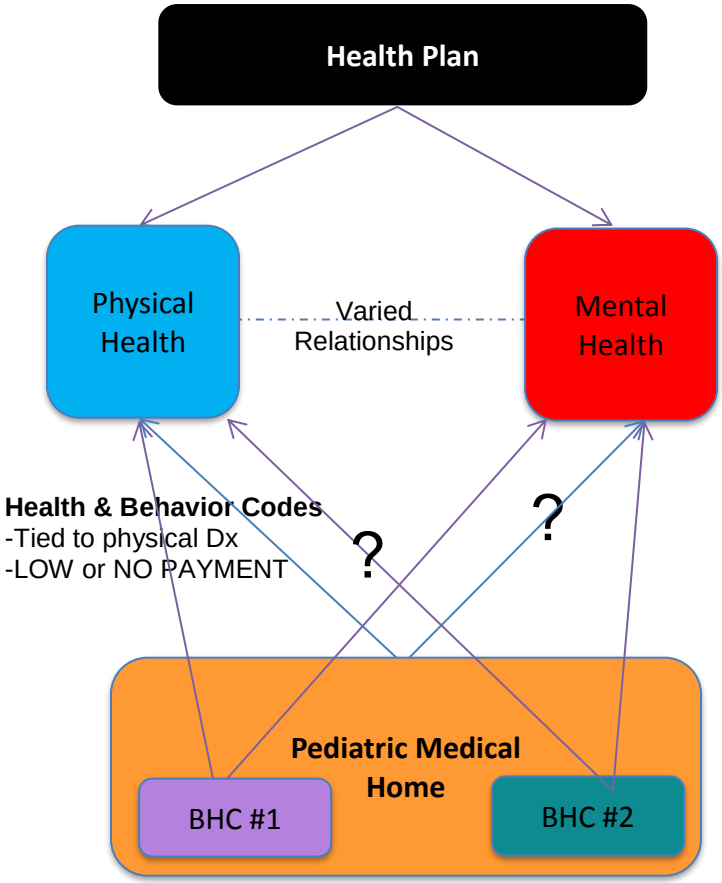
Appendix B: Organizations Endorsing the Recommendations in this Brief

Organization	Endorsement Status
Children's Health Alliance/Children's Health Foundation (CHA/CHF)	Endorsed April 2016
Oregon Council of Child & Adolescent Psychiatry (OCCAP)	Endorsed May 2016
Oregon Pediatric Society (OPS)	Endorsed May 2016
Oregon Association for Behavior Analysis (ORABA)	Endorsed June 2016
Oregon Academy of Family Physicians (OAFP)	Endorsed September 2016
Kartini Clinic	Endorsed October 2016
Oregon Psychological Association (OPA)	Endorsed November 2016
Tri-County Behavioral Health Providers Association	Endorsed December 2016
Oregon Psychiatric Physicians Association (OPPA)	Endorsed January 2017
Western Psychological Services	Endorsed January 2017

Appendix C: Example of Integrated Contracting Structure to Eliminate Barriers to Behavioral Health Integration in Primary Care Practices

Carve-Out Health Plan Structure*



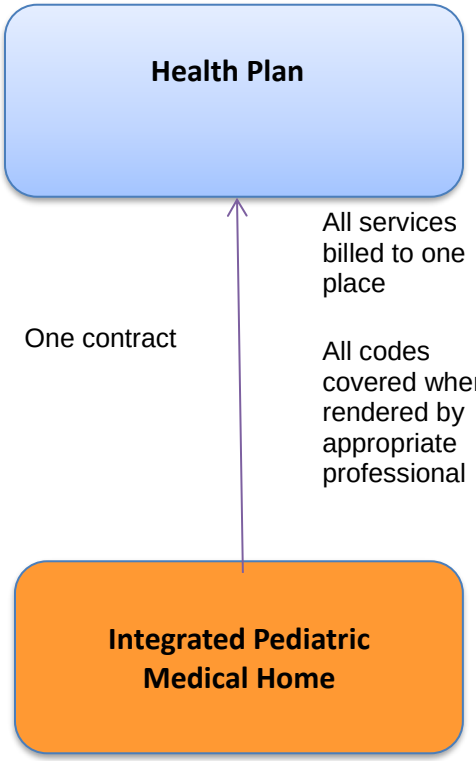
Mental health carved out network - Completely separate contract

Mental Health Codes
-Tied to mental health Dx
-Typical therapy visits
-PAYMENT VARIES SIGNIFICANTLY BY PLAN

Individual contracts with health plan and mental health carve-out (not associated with pediatric clinic)

Integrated Health Care:
NO CURRENT FFS payment for team-based prevention, early intervention, or care coordination

Integrated Health Plan Structure



Integrated Health Care:
PMPM payments for services not covered under FFS structure: team and population-based preventive care including brief assessments & interventions, MD consults, pre-visit planning, warm hand-offs, & care coordination

*Structure complexity increases with multiple CCOs/health plans in the same area and/or multiple physical and mental health networks

Appendix D: Recommended Basic Package of Preventive Behavioral Health Services That All Public and Private Insurance Plans Should Cover at Integrated Patient-Centered Primary Care Homes

Additional Per-Member-Per-Month (PMPM) Payments or other Alternative Payment Model for All Patient-Centered Primary Care Homes that Provide Integrated Health Care to Cover the Following Preventive Non-FFS/Encounter-Based Behavioral Health Services:
Prevention, early intervention, family therapy, and parent education & support for common pediatric behavioral health issues before they reach the level of diagnosable disorders
Same-day brief consultations, assessments & interventions with patients and families
Warm-hand offs between the primary care team and behavioral health clinicians
Behavioral health clinician participation in pre-visit planning, team meetings, and huddles
Consultations between the primary care team and behavioral health clinicians
Care coordination and communication with entities outside the patient-centered primary care home including behavioral health clinicians, psychiatrists, other specialist providers, hospitals, schools and teachers, etc.

[1] **Behavioral health** is an umbrella term that encompasses a wide variety of issues that impact health, including what has traditionally been labeled mental health and substance use conditions, health behaviors, developmental risks and conditions, and overall psychosocial well-being. Integrated behavioral health care in primary care practices may include:

- Mental Health and Substance Use Disorders - e.g., anxiety disorders, depression, substance abuse, eating disorders, schizophrenia, disruptive disorders, etc.
- Developmental Risks/Conditions/Disabilities – e.g., autism, ADHD, learning disabilities, developmental delay, communication & motor disorders, etc.
- Psychological Well-Being and Behaviors – e.g. stress, substance use, habits, nutrition & exercise, resiliency, relationships, problem-solving, prevention of mental/behavioral/developmental health problems, health promotion, behaviors affecting health, family factors/functioning, parental attachment, Adverse Childhood Experiences (ACEs), trauma, etc.

[2] **Integrated Health Care:**
As defined in amended ORS 414.025: "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following: (A) Mental illness (B) Substance use disorders (C) Health behaviors that contribute to chronic illness (D) Life stressors and crises (E) Developmental risks and conditions (F) Stress-related physical symptoms (G) Preventive care (H) Ineffective patterns of health care utilization.

[3] **Behavioral Health Clinician:**
As defined in amended ORS 414.025: "Behavioral health clinician" means: (a) A licensed psychiatrist; (b) A licensed psychologist; (c) A certified nurse practitioner with a specialty in psychiatric mental health; (d) A licensed clinical social worker; (e) A licensed professional counselor or licensed marriage and family therapist; (f) A certified clinical social work associate; (g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or (h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.