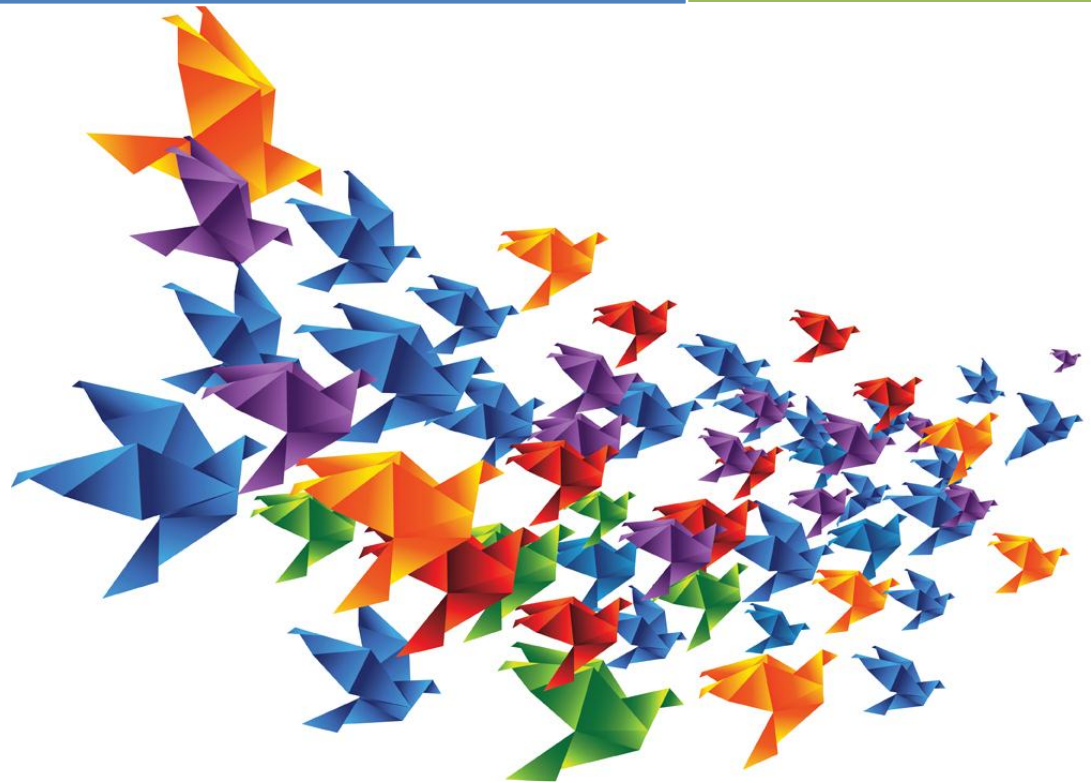


2013

Behavioral Health Integration Task Force



July, 2013

Report to the Legislature
and the Health Policy
Commission

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I. Executive Summary

Chapter 224 of the Acts and Resolves of 2012 is a comprehensive law designed to bring health care spending in balance with the state's economy. At its core, the goal of Chapter 224 is to contain health care costs. Within that legislation, Section 275 established "a special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems."¹

The Behavioral Health Integration Task Force (Task Force) was charged under Section 275 to examine the following six topics:

- the most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care;
- how current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes;
- the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols;
- how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services;
- how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and,
- the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

In addition to its own deliberations, various guests were invited to present on important issues related to behavioral health integration, including the Children's Behavioral Health Advisory Council, experts from health care providers with experience in models of primary and behavioral health integration, and individuals with lived experience. The Task Force also benefited from responses to a request for information (RFI) issued by the Department of Mental Health (DMH), and by community-based stakeholder-feedback session.

¹ Section 275 of Chapter 224 of the Acts and Resolves of 2012, enacted August 2012.

The Task Force established working principles as a foundation to address the six topics identified in the enabling legislation and to build on the existing assets in the behavioral health delivery system. These working principles draw from the proven results in behavioral health care that emphasize the potential for recovery from substance abuse and chronic mental illness, the value of peers and family partners with lived experience in working with individuals and their families as part of care planning and care coordination, and the central place of the individual in participating in the design of his or her care plan.

In the course of the development of these recommendations, the Task Force noted that efforts to integrate primary care and behavioral health services have shown promising but mixed results so far, while also noting that they have revealed a number of persistent barriers to integration, many of which pervade throughout our health care system and are not unique to specific populations. These barriers include, but are not limited to:

- numerous reimbursement issues, including but not limited to lack of equity in behavioral health payments and restrictive billing policies and non-aligned payment systems that inhibit integration and inclusion of behavioral health professionals, peers and family partners on care teams;
- outdated regulations that are based on separate systems for physical health and behavioral health;
- difficulty accessing behavioral treatment;
- the need for significant training and education of both primary care and behavioral health providers;
- lack of interoperability and connection of the behavioral health system to electronic records; and,
- privacy concerns, real or perceived.

The Task Force focused its work on these systems barriers and on solutions that would work for all populations. In doing so, it developed 29 recommendations for consideration by the Legislature and the Health Policy Commission, which not only answer the questions posed with Section 275, but also suggest additional strategies aimed at the successful integration of primary care and behavioral health care to improve health care outcomes and contain health care cost growth. Implementation of a number of the Task Force recommendations will require financial investments. The Task Force recognizes the challenge of considering additional costs in the context of a healthcare cost containment initiative; however it believes that these investments will result in improved health outcomes and an overall reduction in health care costs. The Task Force also acknowledges the need to balance new investments with the equally urgent need to assure that current services are adequately funded.

Together the recommendations put forth in this report address the barriers to integration noted above by broadly providing strategies for:

- A clinical model that expands from a one-to-one relationship between the practitioner and the individual to:
 - a team-based clinical model of integrated care that acknowledges the value of behavioral health professionals, peers and family partners as key members of the team in an integrated primary care setting;
 - interventions that underscore the importance of the team to coordinate a host of services for the individual that will fill the “space between” the health care interventions, work with the individual to identify his/her individual strengths and natural community supports and address the social determinants of health care that often exacerbate the effects of cardiovascular disease, diabetes and obesity among person with serious mental illness; and,
 - an emphasis on prevention and early intervention with children and their families to prevent or mitigate the effects of Adverse Childhood Experiences that often result in chronic medical conditions among adults.
- alignment of incentives to promote provision of integrated care;
- adequate reimbursement for behavioral health services and transparency in alternative payment systems to ensure adequate reimbursement for professionals and non-professionals that are part of a care team;
- enhanced and redeployed behavioral health provider capacity;
- modifications to medical necessity, prior authorization and credentialing criteria and processes;
- balancing of privacy concerns with treating providers need to share and view minimum necessary treatment information;
- training and education focused on integration, including use of persons with lived experience as part of the training and education process; and,
- continued workforce development.

The report does not provide all of the answers to the challenge of successful integration of primary and behavioral health care. Issues of stigma, access to behavioral health services; workforce development and financing, among others, will require the concentrated effort of healthcare providers, policy makers and legislators in the months and years to come. However, the Task Force is confident that as a whole this report sets the Commonwealth on a path towards successful integration.

II. Introduction

Chapter 224 of the Acts and Resolves of 2012 is a comprehensive law designed to bring health care spending in balance with the state's economy. At its core, the goal of Chapter 224 is to contain health care costs. Within that legislation, Section 275 established "a special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems."²

The statute specifies the membership of the Behavioral Health Integration Task Force (Task Force) and names the Commissioner of the Department of Mental Health (DMH) as its chair. In addition to the membership identified within the legislation, representatives from the Department of Public Health's (DPH) Bureau of Substance Abuse Services (BSAS) and the Office of Medicaid were invited to participate in the Task Force. A full listing of Behavioral Health Integration Task Force members is included as Appendix A to this report.

The Task Force was charged under Section 275 with examining the following six topics:

- the most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care;
- how current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes;
- the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols;
- how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services;
- how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and,

² Section 275 of Chapter 224 of the Acts and Resolves of 2012, enacted August 2012.

- the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

To address the topic of behavioral health integration into primary care generally, and the specific questions posed by Section 275, the Task Force met nine (9) times between December 2012 and June 2013.

In addition to the organizations represented on the Task Force, the recommendations of the Task Force were informed by stakeholder and expert feedback collected through three primary sources: a request for information (RFI) issued by the DMH, community-based stakeholder-feedback sessions, and through invited guest speakers to the Task Force meetings.

The RFI was issued by DMH in February 2013. Sixty-five responses from peers, providers, hospitals, trade associations, health plans, licensed independent practitioners and advocacy organizations responded to the RFI in writing. The Task Force members received a copy of each of the responses. In addition, two public forums were held in the communities of Boston and Holyoke. Over 100 participants attended and provided testimony.

The DMH Commissioner also solicited recommendations from two groups. The Children's Behavioral Health Advisory Council, established by *Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental*, provided recommendations to the Task Force related to child and adolescent behavioral health. The Council is a unique public-private partnership representing child-serving agencies, parents, and professionals with knowledge and with expertise in the field of children's behavioral health. The DMH Medical Director convened a Physician Work Group, with representatives from internal medicine, pediatrics, and child and adult psychiatry. Representatives of both groups presented their recommendations to the Task Force, which incorporated many of them into this report.

The Task Force invited several guests to speak representing themselves, organizations, standing advisory committees or ad-hoc groups formed to provide input into the Task Force. Guest and invited speakers included:

- Julian Harris, MD – MassHealth
- Thad Schilling, MD and Dan Gallery, PsyD – Harvard Vanguard Medical Associates
- Sarah Gordon Chiaramida, Esq – Massachusetts Association of Health Plans
- Sandy Blount, EdD – UMass Medical School
- Valerie Konar, UMass Medical School, and Frances O'Hare, MD, Martha Eliot Health Center, representing the MA Child Health Quality Coalition
- Marie Hobart, MD – Community Health Link

- Lester Blumberg, Esq – Department of Mental Health
- Bill Beardslee, MD (Children’s Hospital), Michael Yogman, MD (MA AAP), John Sargent, MD (Tufts Medical), Carol Trust (MA NASW), and Lisa Lambert (PPAL), representing the Children’s Behavioral Health Advisory Council
- Karen Hacker, MD, MPH (Cambridge Health Alliance), and Janet Osterman, MD, (Boston University and President of Massachusetts Psychiatric Society) representing the Ad-Hoc Physician Work Group to the Task Force
- Linda Naimie – individual with lived experience representing herself
- Deb Delman – the Transformation Center
- Naomi Pinson – Advocates, Inc.

See Appendix B for meeting summaries and presentation materials, including background presentations on current integration efforts, recommendations to the Task Force from Advisory Groups and a combined summary of feedback from the Request for Information (RFI) process and public forums described below. Appendix B also includes a listing of additional materials shared by Task Force members.³

III. Definitions

Behavioral Health: an umbrella term that refers to mental health and substance use disorders and their treatment and prevention, and behavioral interventions in physical disease management, health promotion and/or the system of care.

Collateral Contacts: a contact between an individual’s treating behavioral health provider and other providers, school, supports, and/or family members relative to the behavioral health treatment of an individual.

Family: any person defined by an individual who plays a significant role in that individual’s life. This may include a person not legally related to the individual. Members of “family” include spouses, domestic partners, and both different-sex and same-sex significant others. “Family” includes a minor’s parents, regardless of the gender of either parent. The concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parent, step-parents, those serving in loco parentis, and other persons operating in caretaker roles.⁴

Individuals: a child, youth, or adult who has a behavioral health issue or disorder. “Individual” is used throughout this report because the Task Force intends and believes that the integration challenges addressed in this report are system wide and largely not

³ All of these materials will be made available to the Legislature on CD-ROM and will be posted on DMH’s website.

⁴ Definition source adapted from <http://www.hrc.org/resources/entry/lgbt-inclusive-definitions-of-family>.

unique to specific populations. Where important distinctions do exist for specific populations, they are noted and specific reference is made to children or youth or adults.

Integrated risk bearing provider organization: a broad term to define organizations that provide both behavioral health and physical health services in a coordinated fashion and accept financial risk for the provision of healthcare to the individuals it serves. This term encompasses all organizations that operate in an integrated way, regardless of the model of integration they choose or the extent to which they are at financial risk for the services they provide.

Persons with lived experience: individuals who have had or currently have behavioral health issues or disorders and have accessed some portion of the health care, mental health care or the substance use delivery system. These individuals include adults, children and family members caring for children with behavioral health issues or disorders.

Provider: any licensed or non-licensed health care professional, provider or peer supporter who has the potential to be part of an integrated care team. Such providers include, but are not limited to: physicians, nurse practitioners, psychologists, psychiatrists, advanced practice psychiatric nurses, alcohol and drug use counselors, licensed independent clinical social workers, licensed mental health counselors, peer counselors, visiting nurses, family therapists and family partners. The term “provider” can also refer to community-based organizations, hospitals, and schools that provide mental health and/or substance use services and employ many types of individual providers.

IV. Background

Historically, physical and behavioral health care (used throughout this report to refer to substance use and mental health services) have been provided through separate systems by separate providers, with separate financing streams. Although some behavioral health care has always been provided within the general medical care system by acute care general hospitals and primary care and other providers, this care is often provided without the benefit of providers with specialized training and without the resources for consultation and integration. Much has been written about the need for greater behavioral health integration within the provision of physical health care and improved physical healthcare within behavioral health settings. Numerous professional organizations have issued white papers on primary and behavioral health integration. There are innovations and promising practices in Massachusetts in both the child and adult systems: the Patient-Centered Medical Home Initiative, MY CHILD / Project LAUNCH, the Massachusetts Child Psychiatry Access Project (MCPAP), and the Dual Eligible Initiative.

Over the course of a year, nearly 30 percent of the adult population in the United States suffers from a behavioral health disorder, with a high prevalence of mood, anxiety and substance use disorders.⁵ Behavioral health problems are 2-3 times higher in patients with chronic conditions, including diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease.⁶ Untreated behavioral health disorders lead to functional impairment and complications with physical health care issues, and result in higher health care costs.⁷ Further, treatment of behavioral health conditions with pharmaceuticals may increase the likelihood of some chronic conditions.⁸ Moreover, individuals with a serious mental illness live, on average, 25 years less than individuals without behavioral health issues in part due to treatable medical conditions including smoking, obesity, substance use, and inadequate access to medical care.⁹ Similarly, individuals with substance use disorders live, on average, 22.5 years less than those without the diagnosis.¹⁰ In addition, there are behavioral factors which influence physical disease management and health promotion.

Children are not “cost drivers” when compared to some groups of adults, such as adults eligible for both Medicaid and Medicare. However, both childhood physical and mental health problems result in poorer adult health. Furthermore, childhood mental health problems have much larger impacts than do childhood physical health problems on four critical areas of socioeconomic status as an adult: education, weeks worked in a year, individual earnings, and family income. Without intervention, child and adolescent psychiatric disorders frequently continue and worsen into adulthood and are increasingly associated with disability and increased medical costs. For example, mental health problems in childhood are associated with a 37 percent decline in family income, three times greater than the decline related to having physical health problems.¹¹

⁵ Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-627.

⁶ Katon, Wayne, Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness, *Society of Biological Psychiatry*, 2003;54:216-226; Katon, W. Lin, EH, and Kroenke, K. The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. *Gen. Hosp. Psychiatry*. 2007; 29:147-155.

⁷ Kessler et al., 2005.

⁸ Muench J and Hamer A. “Adverse effects of antipsychotic medications.” *American Family Physician* 617-622 (2010) and O’Riordan M. et al. “Antidepressant use linked with increased atherosclerosis.” *Medscape* April 14, 2011.

⁹ Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006.

¹⁰ Neumark, Y.D. et al. “Drug dependence and death: Survival analysis of the Baltimore ECA sample from 1981 to 1995.” *Subst Use Misuse* 2000;35(3):313-327

¹¹ Delaney L and Smith J. “Childhood health: trends and consequences over the life course.” *Future Child*. Vol. 22, No 1, Spring 2012.

The first signs of mental illness often occur in childhood. Half of all lifetime mental illnesses begin by age 14 and three quarters begin by the time an individual is 24.¹² Approximately 20 percent of children and adolescents experience signs and symptoms of a diagnosable mental health disorder during the course of a year. For children between the ages of 9 and 17, 11 percent experience “significant impairment” and five percent experience “extreme functional impairment.”¹³ Adolescents who begin drinking before age 15 are four times more likely to develop alcohol dependence some time in their lives compared with those who have their first drink at age 20 or older.¹⁴ Moreover, the Adverse Childhood Events literature underscores the impact of the consequences of adverse childhood events on adult physical and behavioral health morbidity, mortality and costs.¹⁵ There is clear and expanding scientific evidence that toxic stress, associated with adverse child events, can permanently alter brain maturation broadly and particularly in the prefrontal cortex, hippocampus and amygdala, as well as the nerve interconnections between them. These brain changes may be permanent and once established, may not change easily, underscoring the importance of prevention and early intervention.¹⁶

While individuals with behavioral health needs may obtain behavioral health care through a specialty behavioral health provider, most behavioral health treatment for adults is provided in primary care settings¹⁷ or in acute care general hospital systems of care. A larger number of adults with a behavioral health disorder receive their treatment in primary care (22.8 percent) than in a specialty mental health setting (20 percent). Many adults (49 percent) only receive medication and no further treatment.¹⁸ Moreover, over 60 percent of adults with a diagnosable disorder and 70 percent in need of treatment do not receive any mental health services.¹⁹ On the other hand, children and adolescents are less likely than adults to receive behavioral health care in medical

¹² National Institute of Mental Health (NIMH) Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005.

See also, Mental Health Surveillance Among Children - United States, 2005-2011, The Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Supplement Volume 62, No. 2, May 17, 2013.

¹³ Mental Health: A Report of the Surgeon General, NIMH, 1999.

¹⁴ Califano, Joseph. Center on Addiction and Substance Abuse (CASA) press release, 2-26-02; NIAA Alcohol Alert #59, April 2003, Grant, B.F. et al Journal of Substance Abuse 9:103-110, 1997.

¹⁵ http://vetoviolence.cdc.gov/childmaltreatment/phl/resource_center_infographic.html

¹⁶ Shonkoff JP et al. “Neuroscience, molecular biology and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention.” *JAMA* 2009; 301(21): 2252-2259.

¹⁷ Wang, PS., Lane, M., et al. “Twelve-month use of mental health service in the United States: results from the National Comorbidity Survey Replication” *Arch Gen Psychiatry*, 2005 June, 62(6):629-40 and Wang PS, et al. “Changing profile of service sectors used for mental health care in the U.S.” *American Journal of Psychiatry*, 163(7), 1187-1198. 2006.

¹⁸ *Mental Health Financing in the United States*, Kaiser Family Foundation, April 2011. Accessible at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8182.pdf>

¹⁹ Ibid.

settings and more likely to receive care through their school or through a behavioral health provider.²⁰

Multiple barriers prevent primary care providers (PCPs) from providing optimal care especially for individuals with more complex behavioral health needs. To truly serve the whole patient, it is important for the PCP to have the capacity to identify and treat or refer, as appropriate, individuals with behavioral health needs. Research demonstrates the value of integrating behavioral health services with primary care, including for anxiety and substance use disorders²¹ and basic bio-psycho-social factors in the health care delivery system. Likewise, there is a pressing need to improve the quality of physical health care in behavioral health settings.

There is no “one size fits all” approach to caring for individuals with behavioral health needs, and the approach to effective care may differ by care setting and population. The Task Force considered several clinical models of behavioral health integration that are applicable to the primary care and outpatient behavioral health setting, and recognizes that it is important to support integration across a spectrum of settings and populations. A description of clinical models of behavioral health integration is included as Appendix C.

Increased focus on improving quality while reducing the cost of health care across the United States has heightened interest in the integration of behavioral health and general medical care, particularly where provider groups are beginning to take on financial risk for a group of patients under alternative payment methods. However, efforts to integrate primary care and behavioral health services have shown promising but mixed results so far, and have revealed a number of persistent barriers to integration, including:

- numerous reimbursement issues, including but not limited to lack of equity in behavioral health payments and restrictive billing policies and non-aligned payment systems;
- outdated regulations that are based on separate systems for medical health and behavioral health;
- difficulty accessing behavioral treatment;
- the need for significant training and education of both primary care and behavioral health providers;

²⁰ Burns BJ et al. “Children’s mental health service use across service sectors.” *Health Affairs*, 14, no. 3 (1995): 147-159.

²¹ For anxiety: Price D et al. “The treatment of anxiety disorders in a primary care HMO setting.” *Psychiatr Q.*, Spring 2000, 71(1):31-45; For substance use: Parthasarathy, S. et al., “Utilization and cost impact of integrating substance abuse treatment and primary care, medical care” *American Public Health Association*, March 2003- Volume 41, Issue 3, pp. 357-367.

- lack of interoperability and connection of the behavioral health system to electronic records; and,
- privacy concerns, real or perceived.

Many of these barriers are system-wide and not unique to specific populations. The Task Force has viewed its work as focusing on these systems barriers and developing solutions that would work for all populations. In developing its recommendations, the Task Force explored these barriers; a more in-depth discussion of each topic area is presented below.

Reimbursement

There are three major categories of barriers to integration related to reimbursement – the first is related to rates of reimbursement that do not cover the actual cost of providing such services, the second is related to administrative barriers and the third is the non-alignment of payment systems.²²

A key barrier to the integration of behavioral health with primary care is low reimbursement rates for behavioral health services and the historical failure of the fee-for-service model to pay for care management services, consultation among providers, collateral contacts, and for some, the electronic systems needed for an integrated environment. Some behavioral health providers are not reimbursed by insurers or are restricted to a limited subset of their statutory scope of practice.

There is a concern among some in the behavioral health community that as integrated provider networks form and more services are paid through alternative payment methodologies, behavioral health services will continue to not be adequately utilized nor reimbursed within primary care settings, without appropriate measures. There is also a concern that behavioral health services in the behavioral health setting will continue to be inadequately reimbursed. In addition, some behavioral health providers note that pay-for-performance incentives can be a barrier to reimbursement as outcome measures are harder to quantify in behavioral health than in physical health care.

There are several administrative barriers to reimbursement, including prohibitions on billing for more than one visit in a day and limitations on which providers can bill different codes. In addition, while behavioral health carve-outs were initially developed in order to ensure provision of behavioral health services, there is now concern that the carve-out of behavioral health to separate vendors may become a barrier as the different

²² Mauch D, Kautz C, Smith S. “Reimbursement of Mental Health Services in Primary Care Settings”. Prepared for the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center Mental Health Services, February 2008.

organizations potentially try to shift coverage to the other vendor and not pay for provision of services.

The non-alignment of payment systems is a complex topic. There is recognition that behavioral health services, if provided under integrated funding models, can significantly contribute to improvement of total health care costs. Under such models all providers would be attentive to the importance of improving total health, including behavioral health, and could share together in shared savings models. At the same time there is general recognition of the importance of preserving special funding streams for specialty behavioral health and ensuring that in any integrated funding system, quality measures and funding metrics would be set in such a way as to protect the funding for behavioral health services.

Privacy

One of the primary barriers to behavioral health integration is the persistent stigma and discrimination to which society subjects individuals receiving behavioral health services. The reaction to this discrimination results in a desire for more privacy and a reluctance to share clinical information. This stigma has been persistent over many decades and extends beyond the health care system. Health care professionals are not above reproach. In one study, for example, nurses were found to act as “stigmatizers,” carrying negative attitudes founded on the belief that individuals with mental health issues are dangerous, weak and to blame for symptoms.²³ These attitudes are most often directed toward individuals with previous hospital admissions, those who are actively presenting symptoms, or those who are diagnosed with what is perceived as a long-term illness, such as schizophrenia, as opposed to individuals who do not exhibit significant symptomatology.²⁴ While theoretically, better health care decisions would be the result of complete information about the person receiving services, this is not always the case in practice.²⁵

Many health care plans and primary care providers, however, think that privacy laws, regulations and policies and the interpretation of such within the behavioral health and physical health system hinder integration and the provision of quality health care. Primary care providers can be challenged by the behavioral health system not sharing important information that may be necessary to support the treatment of an individual or family (e.g., medications prescribed by a psychiatrist, discharge notification from an inpatient psychiatric unit or detoxification program.) Behavioral health providers may apply the strictest interpretation of privacy laws to protect the people they treat from

²³ C Ross and E. Goldner. “Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature.” 16. *J Psychiatric and Mental Health Nursing*. 558-568 (2009).

²⁴ H. Roa et al. “A study of stigmatized attitudes towards people with mental health problems among health professionals.” 16 *J. Psychiatric and Mental Health Nursing*. 279-284 (2009.)

²⁵ P. Corrigan, *How Stigma Interferes with Mental Health Care*, 59 *American Psychologist* 614, 621 (Oct. 2004) .

unintended consequences of revealing personal information which might actually impede the provision of quality healthcare or be overly intrusive or because of fear of liability of releasing information. Primary care providers are often unaware of additional federal privacy protections for persons with substance use disorders and require training in the use of appropriate release of information in order to facilitate integration. This push-pull of individual health care information needs to be balanced in order for behavioral health integration to be successful.

In addition all members of the Task Force acknowledge that it is important to consider the individual's view of privacy. The Task Force learned that some individuals avoid seeking care from trained behavioral health providers or sharing behavioral health concerns with medical providers due to the stigma previously described. The Task Force learned from Dr. Frances O'Hare, an internist from Boston Children's Hospital, that confidentiality is of utmost importance in engaging adolescents in behavioral health treatment.²⁶ Indeed, there are unique concerns related to privacy and confidentiality for adolescents and their families. In addition, the sharing of information with healthcare providers in schools (i.e., school nurses, counseling personnel) in order to address children's behavioral health issues must be considered.

The Task Force heard from individuals with lived experience who experience stigma in the health care system. They shared their experience and the experience of their friends and loved ones who have had physical health symptoms ignored because of their behavioral health diagnosis. While this stigma is often one of the reasons some persons with lived experience prefer to not have their behavioral health diagnoses or record information shared with medical providers from whom they may seek care, others report wanting trusted health care professionals to have access to their entire health care record. However, they uniformly wanted to be able to make the choice about with whom to share this information themselves.

The Task Force responded to the issues of stigma in the Education and Training recommendations and responded to the information-sharing concerns in the Privacy recommendations.

Regulatory

There are many outdated regulations that are based on dated and separate medical, mental and substance use health systems. These regulations impede integration. For example, some Plan Review Guidelines applicable to new construction or renovations might require separate waiting rooms for physical health and behavioral health patients, which may contribute to stigma and discrimination (addressed in the privacy barrier

²⁶ Frances O'Hare. Presentation to the Behavioral Health Integration Task Force. April 16, 2013. For more information, see Appendix B.

below). Furthermore, the regulation poses a potential burden on integration efforts as typically providers do not have extra space for separate waiting rooms. However, the Department of Public Health (DPH) may and has waived such requirements to facilitate integration. In addition many intensive behavioral health settings cannot currently qualify for the cost-based reimbursement found provided to community health centers (CHCs).

These barriers exist today within a mostly fee-for-service system, and become increasingly problematic in a shift to alternative payment methodologies. The Task Force recognizes that the DPH has established a procedure for identification and waiver of regulatory barriers, in appropriate cases, for organizations interested in integrating services and the Task Force supports the continuation of this work in its recommendations.

Education and Training of the Workforce

The Task Force considered the barriers to education and training of the workforce and noted that the health care workforce is not trained sufficiently to work together in an integrated environment. Under current reimbursement systems, PCPs are paid in such a way that the pressure to be productive may result in the provider having little time to receive education on integration and no time or resources to deliver integrated care.

Many behavioral health providers also lack training in providing integrated care. Many medical conditions have significant behavioral components (e.g., diabetes in adults) or root causes (e.g., trauma and toxic stress experienced by children) that could be positively impacted by integrated health interventions. However, most behavioral health providers lack the necessary training to be able to offer such interventions in an integrated care setting or to oversee medical care needs in a behavioral health setting. They suffer from even greater pressures for productivity due to inadequate payment, resulting in similar lack of time for such training.

While time and funding for educational programs can help mitigate some of the barriers, the normal human reactions to changes in the environment (the health care system) also pose a barrier. There are often misperceptions about the other provider type and their role in an integrated environment and significant cultural differences in style of practice - which leads to a fear that individual roles in new and alternative payment models will be threatened.

To help mitigate these concerns, the Task Force provided recommendations to: improve training for all health care professionals on integration; integrate peers into the primary care and other health settings; train traditional medical professionals to recognize behavioral health conditions and behavioral factors in health promotion and disease management; provide treatment within the scope of their practice; enhance the training

of behavioral health professions to recognize the importance of medical issues in the behavioral health setting and for all to recognize the inter-relationship between physical health and behavioral health conditions for both children and adults.

V. Guiding Principles

The Task Force developed and unanimously adopted on April 8, 2013 a set of guiding principles for including behavioral health integration in alternative payment models. The fifteen guiding principles are as follows:

1. Integrated behavioral health services should include a continuum of all prevention, screening, assessment, diagnosis, support, care management, recovery self-management, consultation and treatment services, which can be reasonably provided within any care, community, or recovery-oriented setting for mental health and substance use disorders and the development and maintenance of a healthy lifestyle.
2. The services listed and implied within Principle #1 should be provided in a multi-disciplinary team approach by a wide variety of skilled individuals in accordance with their practice license, certification, accreditation or common practice.
3. Models for the delivery of services listed and implied within Principle #1 should be based on evidence when available.
4. The services listed and implied within Principle #1 should be based on evidence of safety and effectiveness as derived from research, expert consensus, and lived experience. The services should be culturally competent and developmentally appropriate.
5. There are multiple acceptable models and locations for including and providing the services listed and implied within Principle #1, and payment for those services should reflect the variety of models and locations.
6. All models that include and provide the services listed and implied within Principle #1 should be person- and family-driven and recognize the unique needs of the population served.
7. All models that include and provide the services listed and implied within Principle #1 should respect the goals of persons receiving services, as well as their preference for clinician and mode of treatment.
8. Persons with lived experience should be involved in the policy development, evaluation, and training of models of care and delivery of services listed and implied within Principle #1.
9. Payment for all services listed and implied within Principle #1 and that occur in various settings should be sustainable, transparent, support service delivery and

infrastructure development. The payments should reflect the importance of these services to integrated health care organizations.

10. Payment for all services listed and implied within Principle #1 should not limit access to emergency, inpatient and intensive services in specialty mental health settings.

11. Payment for all services listed and implied within Principle #1 should include support for the acquisition of and integration of EMR from specialty behavioral health providers.

12. Financial incentives and the distribution of payment within alternative payment models should be tied to quality of care and include all medical and behavioral providers in an integrated manner.

13. The Task Force recommendations should balance the clinical interest for bi-directional communication between those who provide the services listed and implied within Principle #1 and the privacy of individuals and their families receiving services.

14. The Task Force recommendations of the models and locations for including and providing the services listed and implied within Principle #1 should be based on demonstrated evidence-based care and where such evidence is not available, based on a consensus of the medical community, behavioral health community, mental health community and/or substance use disorder community, on practice experience or informed by lived experience.

15. The Task Force recommendations should have measurable outcomes, where such outcome measures exist.

VI. Recommendations

The recommendations of the Task Force focus primarily on answering the six specific questions included within the legislation, and build off of the guiding principles described above. There are additional recommendations that are relevant to the successful integration of behavioral health and primary care that are not specific to the legislation. Those recommendations are included at the end of this Report.

Implementation of a number of the Task Force recommendations requires an additional financial investment. The Task Force recognizes the need to consider any additional costs in the context of improved health outcomes and an overall reduction in health care costs. It also acknowledges the difficulty in requesting additional funding for new services and innovations when current services may not be appropriately funded. The Task Force has strived to include recommendations which appropriately align incentives to result in provision of integrated care to meet the ultimate goal of Chapter 224.

A. Clinical Models of Integration

The most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care.

1. Massachusetts providers should move toward new and emerging models of integration with the most practice-based, evidence-based effectiveness, recognizing diversity in model-type and the needs of individuals and families with lived experience.

Rationale: There are many acceptable models for integration, including new and emerging models that include behavioral health services, being delivered in many loci of care. The most effective and appropriate approach to including behavioral health services is dependent upon the population of individuals being served by each provider. Providers should have the flexibility to provide integrated services in a manner which fits the skills, readiness and appropriateness of their organization and the health care system in which they practice and where the person or family served is most comfortable. A broad range of care options should be available to all patients and used as clinically appropriate. To the extent possible, models of integration should rely on the best published evidence or emerging practice for effective care. A range of provider types must also be available to patients. The move towards integration should continue to allow for and promote innovation in care delivery. In addition, it should include a strong evaluation component in order to assess their cost-effectiveness and to promote continuous quality improvement.

Implementation Action Steps: The models for integration chosen by any given provider (including but not limited to primary care provider, community mental health center, community health center, addiction treatment provider, schools, and hospitals), should take into account the needs and diversity of the individuals who obtain care in that setting. Once individuals have been identified as having a behavioral health disorder, providers can use a number of models, including the National Council's Four Quadrant Model, included as Appendix D), as a way of identifying where individuals or families could potentially receive the most appropriate level of care within various integrated care settings. The Four Quadrant Model represents a population-based

planning framework for the clinical integration of health and behavioral health services²⁷ as does the work of the Substance Abuses and Mental Health Services Administration (SAMHSA) funded AIMS center at the University of Washington.²⁸

Patient Centered: All models of integration should be based on the concepts of patient-centeredness. Patient-centered care is respectful of and responsive to individual preferences, needs, and values and ensures that individual values guide all clinical decisions.²⁹ Task Force members agreed that choice of individuals seeking services must be a guiding principle in the delivery of behavioral health services. They also agreed that individuals must have access to all provider disciplines licensed to provide services under insurance laws and regulations. However, some Task Force members believe that individuals and families should have the opportunity to select the type of care setting³⁰, the composition of the care team and the care services received – regardless of what providers and services are available within an integrated care setting.³¹ Others felt that individuals and families should have the opportunity to select from available settings, providers and services within an integrated care system and that the benefits of seeking care from within an integrated care system should be made known. Services in general should include those not found in traditional medical models of care.

Peer Supports: Peer supports, including family partners with “lived experience” raising a child with behavioral health challenges and youth mentors, should be a standard service that is readily available. Peer supports are critical for initial and on-going engagement of families and youth who might be reluctant to or lack knowledge about and/or skills for engaging with behavioral health care. Engaging families and youth is more than just the receipt of services for their children. Patient and family engagement should include patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, evaluation, and policy-making – to improve health and healthcare.³²

Screening: Providers must use nationally recognized, evidence-based and age-appropriate screening tools³³ (e.g., Screening, Brief Intervention and Referral to

²⁷ National Council for Community Behavioral Healthcare. “Four Quadrant Model.” <http://www.thenationalcouncil.org/galleries/resources-services%20files/5.%20Four%20Quadrant%20Diagram.pdf>. SAMHSA-HRSA Center for Integrated Health Solutions.

²⁸ <http://uwaims.org/>

²⁹ Institute of Medicine. “Crossing the quality chasm: a new health system for the 21st century.” 2001.

³⁰ Including the home.

³¹ J. Hibbard and J. Greene, *What The Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs*, 32 *Health Affairs* 207-214 (2013).

³² Carman KL, et al. “Patient and family engagement: a framework for understanding the elements and developing interventions and policies.” *Health Affairs* 32. No. 2 (2013): 223-23.

³³ Providers should also use consensus-based screening tools that may not have a strong evidence-base.

Treatment (SBIRT) for substance use disorders, PHQ-9 for depression screening, CRAFFT for adolescent addiction screening) to identify individuals who may have behavioral health disorders. MassHealth has endorsed nine evidence-based screening tools for children and youth.³⁴ Despite the potential benefits of universal screening, full implementation has been met with some resistance. Some cite the low yield of true cases, while others cite the costs associated with follow-up of positive screens, and insufficient resources for subsequent behavioral health evaluation and treatment. These limitations should be considered and addressed.

Care Teams: Care teams within integrated care settings should include broad types of primary care and behavioral health providers. In addition to the primary medical team, this should include, but is not limited to, licensed mental health clinicians, alcohol and drug counselors, certified peer specialists and recovery coaches. Behavioral health consultation should be readily accessible to primary care providers including by, but not limited to, qualified psychiatric physicians as in the MCPAP model. A range of options which support strong working relationships between behavioral health providers and primary care providers should be developed and promoted. These options include, but are not limited to, coordinated services, co-location of services and fully-integrated services. The core elements of a successfully integrated model in cases where a behavioral health concern is identified, include, but are not limited to:

- the primary care provider having access to a behavioral health provider for clinical consultation, when needed; and
- connecting an individual or family either for a diagnostic evaluation, brief intervention or longer term services with a behavioral health provider of their choice, regardless of whether the provider is part of the integrated model.

Behavioral Health Consultations: A licensed behavioral health provider whether on site or not should provide “curbside” consultation to the primary care provider. These consultations might be brief. Access to psychiatric consults will likely be through a combination of on-site and off-site (including the potential for “virtual” or telemedicine consults – see Recommendation #22), since most primary care practices will not generate enough need to support a full-time licensed behavioral health care professional on site. In addition, provisions must be made to insure that all non-prescribing behavioral health practitioners have access to prescribers for those individuals for whom medication is indicated.

Care Coordination: Care coordination should also be available as a standard of care for all individuals receiving both primary and behavioral health care from multiple providers. For some, the PCP’s on-going relationship means that they will be best able to provide

³⁴ <http://www.mass.gov/eohhs/docs/masshealth/cbhi/mh-approved-screening-tools.pdf>

care coordination. However, behavioral health providers might be better able to coordinate care for individuals with significant behavioral health conditions. One approach to coordination is the MA Child Health Quality Coalition’s Care Coordination Task Force’s Care Coordination Framework, which identifies a structure for implementing care coordination as a standard of care. The Framework was developed by a multi-stakeholder task force with strong family representation and builds on implementation experiences nationwide. It offers a foundational set of care coordination services that is broadly applicable independent of condition, severity/ acuity, or age, including adults, with the obvious additions of references to schools and transitions from pediatric to adult care.

Key Elements of High-Performing Care Coordination Linked to Process, Structure, and Outcome Measures to Monitor Their Adoption

1. Needs assessment for care coordination and continuing care coordination engagement
2. Person-centered care planning and communication
3. Roles of peer supports as member of the care team
4. Facilitating care transitions (inpatient, ambulatory)
5. Connecting with community resources and schools
6. Transitioning to adult care

The care coordination model seeks to assist primary care clinicians and behavioral health providers to fill “the space between”³⁵ the appointments that the child and family need in order to address the primary care, behavioral health, social, and educational needs of the child. The success of this model is dependent on the engagement of the providers with the family, which in turn, can best be achieved by working with the parent, child and family as a whole to identify their strengths and preferences and by helping them build skills to have an active voice and choice in the services they receive. The value of “family voice and choice” is a foundation of the Wraparound model (a care planning approach) that is integral to the Children’s Behavioral Health Initiative.

Prevention: Prevention of behavioral health disorders and the promotion of health, wellness and emotional wellbeing should be core components of an integrated model. Prevention should focus both on young people as well as adults. Research has shown the promise and potential lifetime benefits of preventing behavioral health disorders are greatest by focusing on young people and that early intervention can be effective in delaying or preventing the onset of such disorders.³⁶ Children’s development into healthy adulthood should be supported through prevention and early intervention

³⁵ Richard Antonelli, MD. Presentation to the Children’s Behavioral Health Advisory Council.

³⁶ National Research Council and Institute of Medicine. “Preventing mental disorders and substance abuse among young people: progress and possibilities. Washington, DC: 2009. National Academies Press.

services and supports. Families with risk factors for distress and impairment in the child should have access to, as well as support for, engagement with, helpful resources that are community-based and culturally competent.

Monitored for Effectiveness: Models of integration that are pursued by Massachusetts providers should be studied to monitor effectiveness and for the purposes of building an evidence-base. Monitoring should include studying the behavioral health and medical health outcomes of patients as well as patient and provider satisfaction. Outcomes should be measured using standards that support healthy development (in children) and recovery (for adults). Recommendations to assess the cost outcomes of alternative payment models used to support these clinical models are outlined in Recommendation #6. Until such an evidence base is developed, the Task Force encourages ongoing pilots of integrated care settings,³⁷ including those focused on the biopsychosocial models and the impact of including peers as part of a care team and careful attention to national demonstration projects and evidence based recommendations.

B. Reimbursement

The extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including: (1) how mental health parity and patient choice of providers and services could be achieved, and (2) the design and use of medical necessity criteria and protocols.

The Task Force recognizes that the financial structure of the fee-for-service system in the current health care delivery system does not reward improved health outcomes or responsive stewardship of private insurance premiums or the public dollars paid through Medicare and Medicaid. The Task Force supports the development of alternative payment methodologies to advance these goals. For instance, global payments that reimburse providers a fixed fee based on their enrolled patient panel allows more autonomy to allocate professional staff time tailored to the intensity of needs of the individual or family. This model is being implemented in commercial, Medicare and Medicaid settings and allows providers to assign non-clinical staff to coordinate care and to provide additional support to individuals and families outside of direct service time. In particular, the Task Force believes that the use of peers and family partners adds value to health care delivery in two ways: their presence helps the individual engage more fully in care, and they provide an additional resource to the clinician to address gaps in “the spaces between” the care the individual or his/her family receive.

³⁷ Including, but not limited to, the Patient Centered Medical Home, integrated risk bearing provider organizations, and the Behavioral Health Home.

The Task Force recognizes that several key components of a high quality integrated program – behavioral health screening, care coordination and deployment of peers and family partners – are missing in the current fee-for-service reimbursement structure and need to be added in the absence of a global payment model that is comprehensive enough to improve outcomes and achieve cost savings through reduced use of more restrictive and costly health care services.

In addition to specific services to be reimbursed and alternative methods for paying for them, the Task Force also recommends investing in important systems infrastructure and supports, e.g., MCPAP and community-based prevention and wellness programs.

2. Ensure reimbursement for behavioral health screening for all children across all payers.

Rationale: Nationally, the average delay between onset of symptoms and biopsychosocial intervention for children is between 8 and 10 years – critical developmental years in the life of a child.³⁸ Behavioral health screening using validated tools provides an effective, evidence-based approach for increasing early identification and intervention, which can both improve outcomes and reduce the costs of mental illness.³⁹ Since 2008, MassHealth has required and reimbursed PCPs to conduct behavioral health screening at well child visits (up to age 21) as required by Medicaid’s Early Periodic Screening Diagnosis and Treatment (EPSDT) provision.⁴⁰

Implementation Action Steps: All payers should be required to reimburse PCPs for administration, scoring, and interpretation of behavioral health screening at every well child visit for children up to age 21. All PCPs must be educated about their obligation to provide behavioral health screening; particularly providers in the adult system who care for transition-age youth (18 to 21) and might be unfamiliar with this requirement. Reporting must occur on a frequent and on-going basis in order to monitor and improve practice at this critical first step in accessing behavioral health care services.

The behavioral health screening requirement should be broadened in two ways. First, post-partum screening at well child visits for parents of children ages 0 to 6 months should be covered by the behavioral health screening requirement. Some providers have explained the low rate of screening for this age group as due to the lack of an

³⁸ Best Principles for Integration of Child Psychiatry into the Pediatric Health Home, American Academy of Child and Adolescent Psychiatry. 2012

³⁹ Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

⁴⁰ <http://www.mass.gov/eohhs/docs/masshealth/cbhi/mh-approved-screening-tools.pdf>

appropriate screening tool.⁴¹ Postpartum depression has a significant adverse effect on young children's cognitive and emotional development in the preschool years. Treating maternal depression improves the cognitive and social emotional development of young children even in the absence of any direct intervention with the child.⁴²

Second, reimbursement for both a mental health screening and a substance abuse screening in a single visit should be allowed when the PCP deems it necessary for a youth's health. Currently, providers are limited to one screening and must choose between screening tools that may not cover both mental health and substance abuse.

Despite the potential benefits of universal screening, its limitations, including low yield of true cases, costs associated with follow-up of positive screens, and insufficient resources for subsequent behavioral health evaluation and treatment, should be considered and addressed. Moreover, providers must be informed about the limits of screens and have access to more thorough diagnostic and assessment services when indicated.

Some Task Force members are concerned that too often, medication is prescribed to children too quickly and that care should be taken to ensure that a positive mental health screen does not automatically lead to treatment with medication alone. Some Task Force members believed that there must be safeguards to require that any child screened positive for mental health needs receives a thorough psychosocial evaluation including a family evaluation before medication is administered. However, other Task Force members disagreed with this argument noting that it is within the scope of a PCP's practice to prescribe medication to treat target symptoms (e.g., those that may appear with ADHD) and it is a medical judgment that PCPs are trained and qualified to handle. In addition, some believed that by requiring a thorough psychosocial evaluation, it is possible that clinically and necessary appropriate treatment would be withheld or delayed while awaiting this evaluation. The Task Force ultimately agreed that, where possible, a full evaluation of the child and his or her environment should be undertaken prior to prescription of psychiatric medication. Where it appears in the child's best interest to begin medication immediately, a full evaluation should occur as soon as possible after the start of the medication regimen.

⁴¹ Rosie D. and Mental Health Screening. A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University, Fall 2010.

⁴² Beardslee WR et al. "Children of affectively ill parents: A review of the past 12 years." *J of Am Academy of Child and Adol Psychiatry*, 50, 1098-1109, 2011.

3. Peer supports, including family partners and youth mentors, should be a standard of care. Programs to assist the training and credentialing of peers should be developed and standardized.

Rationale: Peer supports, family partners and youth mentors (broadly referred to as peers in this recommendation) provide a unique and important role in the delivery of behavioral health care and can enhance the care that is provided in integrated settings.⁴³ Studies have shown that the use of peers can improve health outcomes including decreased hospitalizations,⁴⁴ improve quality of life and reduce the number of major life problems.⁴⁵ Peers also play an important role in increasing access as they have the potential to reach individuals who may not otherwise receive care, especially behavioral health care and are viewed as more credible by some individuals.⁴⁶ Studies suggest that use of peers reduces the overall need for behavioral health services over time and, when used as part of hospital-based care, results in shorter hospital stays, decreased readmissions and overall reduction in cost.⁴⁷

The Task Force recommends that payment cover the cost of, promote and encourage the use of, peer support, certified peer specialists and long-term support services, including those traditionally outside the medical model of care subject to appropriate training and credentialing.⁴⁸ Twenty-two states provide reimbursement for peer support through their Medicaid program.⁴⁹ Today, MassHealth reimburses family partners as part of the Children’s Behavioral Health Initiative (CBHI). On a smaller scale, MassHealth has funded “Therapeutic Mentor” services to support skill building and effective use of treatment by youth.

Implementation Action Steps: Provider organizations should use peers as part of normal day-to-day patient care to reduce stigma and support individuals in treatment of their behavioral health disorder. Peers should come from the communities of the people

⁴³ The expanded presence of peer providers in the health care system has the added benefit of combatting stigma that contributes to health disparities faced by persons with behavioral health histories.

⁴⁴ Simpson E and House A. “Involving users in the delivery and evaluation of mental health services: systematic review.” *BMJ* 2002, November 30; 325 (737): 1265.

⁴⁵ Felton CJ et al. “Consumers as peer specialists on intensive case management teams: impact on client outcomes.” *Psychiatr Serv.* 1995 Oct; 46(1): 1037-44.

⁴⁶ Amy Woodhouse and Ashley Vincent. “Development of peer specialist roles: a literature scoping exercise.” Scottish Recovery Network and the Scottish Development Centre for Mental Health. August 2006.

⁴⁷ Chinman, M., Weingarten, R., Stayner, D., and Davidson, L. (2001). Chronicity reconsidered: Improving person-environment fit through a consumer run service. *Community Mental Health Journal*, 37(3) 215-229.

⁴⁸ For other services typically offered outside of the medical model of care see L. Goodman et al., “Within and Beyond the 50-Minute Hour”, 69 *J. of Clinical Psychology* 182-90 (2013).

⁴⁹ Daniels, A., et al. “Pillars of peer support – 2: expanding the role of peer support services in mental health systems of care and recovery. February 2011. <http://www.pillarsofpeersupport.org/POPS2010-2.pdf>

that are served. As a first step, commercial and public health insurers must recognize the role that trained peer supporters play and allow for their services to be reimbursed as a unique provider type. Many Task Force members prefer that credentialing or certification be a requirement for reimbursement as a unique provider type under the fee-for-service payment system. These Task Force members note that without certification requirements, the standard of peer support provided could vary. However, within an integrated risk bearing provider organization that receives global payments, the Task Force agreed that a provider organization should bear the responsibility of training and be encouraged to use trained peer supports, whether certified or not. The Task Force recommends that at a minimum, training of peer supports (either by integrated risk bearing provider organizations or as part of a certification process) include:

- education on privacy and their responsibility for maintaining confidentiality;
- how to provide information and support for physical health conditions or concerns;
- how to give assistance with independent living skills and productivity issues;
- developing social and recreational skills;
- crisis planning; and,
- developing recovery and resiliency skills.⁵⁰

Integrated risk bearing provider organizations must make a reasonable attempt to hire peers who are culturally similar to the population served.

4. Behavioral health services should be included in alternative payment methodologies.

Rationale: Where integrated service models are focused on providing holistic care, behavioral health services are an essential component of an integrated model. Because integration models may differ in levels of integration, the scope of behavioral health services to be provided and reimbursed will also differ based on the model. The provision of integrated behavioral health services, including peer supports, is likely to generate cost containment and improved health outcomes through reduction in unnecessary emergency room usage, avoidable hospitalizations, avoidable re-admissions, and unnecessary office visits. Where a comprehensive set of behavioral health coverage is included within an integrated model, payment should also reflect a comprehensive level of funding for behavioral health services and shared savings models for the total cost of care must include behavioral health providers.

⁵⁰ Certified peer support worker training program. Office of Consumer Affairs. New Mexico Behavioral Health Collaborative. <http://www.bhc.state.nm.us/BHConsumers/OCA CertPeerSpecialistTraining.html>

Many Task Force members expressed concerns with identifying funding for new services when many behavioral health providers do not receive adequate compensation for services that are currently provided.

Implementation Action Steps: Reimbursement or the provision of the following services (in the case of global payments) should be standard within an integrated risk bearing provider organization:

- preventive screenings;
- prevention services and supportive services in primary care settings;
- short term behavioral health intervention (at a minimum), with provisions for appropriate referrals for diagnostic assessments, longer term treatment, specific evidence-based treatments and access to community-based behavioral health services;
- peer support;
- visits with parents without their child present when the focus of the visit is the child's healthcare needs;
- care management;
- care coordination;
- collateral contacts with schools and significant members of the individual's social network;
- long-term support services, including those traditionally outside the medical model of care;⁵¹
- consultative services including telephonic and by other electronic means; and,
- family consultation and social network therapy.⁵²

Rates for consultation time by behavioral health providers must be set commensurate with rate for direct care provision for the identical service which may be based on licensure category, training experience and scope of practice. For instance, MA Licensed Alcohol and Drug Counselors I (LADC I), hold licenses that require education, training and experience on par with other reimbursed behavioral health clinicians such as Licensed Independent Clinical Social Workers (LICSW) and Licensed Mental Health Counselors (LMHC), and their services should be reimbursed accordingly.

Reimbursement methods must cover the cost of adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment

⁵¹ See, e.g., L. Goodman et al., *Within and Beyond the 50-Minute Hour*, 69 *J. of Clinical Psychology* 182-90 (2013) for other services typically outside the medical model of care

⁵² Such as Open Dialogue

services. An effective system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care.⁵³ Accordingly, reimbursement methods must cover the cost of adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. To ensure that the integration of current or new services is successful, the state should study the success of these integration models and inclusion of broader reimbursement on the overall health care spending trend and individual outcomes for both physical and behavioral health care.

Commercial insurers should be required to pay for outpatient methadone treatment services for persons with opiate addiction. Currently, this evidence-based treatment is primarily reimbursed by Medicaid and BSAS dollars pay for persons with commercial insurance. In the context of global payment methodologies, payment for these services may reduce overall health care spending. As a first step in the process, the Legislature should direct the Massachusetts Center for Health Information and Analysis (CHIA) to conduct a study of the cost/benefit of an additional mandate as required by M.G.L. c. 3 § 38C which requires an upfront review of the impact of mandated benefit bills.

Achieving Chapter 224's quality and cost goals requires a broader view of what it means to treat behavioral health and physical health conditions on par with each other. Focusing solely on the amount of services will not be sufficient as PCPs become dependent on the quality of and access to behavioral health services. Quality behavioral health services can help improve primary care outcomes and costs if they are broadly available as well as reimbursed sufficiently and in a manner that allows them to be delivered as recommended in this document. There must be a full array of community-based behavioral health services available to individuals regardless of where they live and what health insurance they have. Currently, MassHealth offers more services than private insurers, particularly for children. Commercial insurers will need to offer an equally broad array in order to achieve quality and cost outcomes for all individuals. Parity also needs to include support for behavioral health interventions (e.g. talking to the patient or family) at a rate based on time and complexity commensurate with rates that support physical health interventions. Reasonable rates will help ensure a sufficient number and range of behavioral health providers and services.

As new payment methodologies are put into place it is important to note that there are many behavioral health providers who are interested but not currently ready to accept risk, and will need assistance in building infrastructure and reserves. The state should make technical and financial assistance available to interested solo practitioners and groups regarding the adoption and use of interoperable EHRs, and the management structures necessary to collaborate with integrated risk bearing provider organizations.

⁵³ Ibid.

5. Insurance Carriers must comply with the Massachusetts parity laws, which state that “...neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.” Ch. 80 of the Acts of 2000; Division of Insurance Bulletin 2000-06.

Rationale: Although the law, Chapter 80 of the Acts of 2000, An Act Relative to Mental Health Benefit, (Parity Law), and subsequent Bulletins released by the Division of Insurance, clearly state that Neuropsychological Testing (NPT) must be treated as a medical benefit and must be covered to the same extent as all other medical services, there are serious challenges that establish barriers and prevent access to care. These include inconsistent standards among payers which result in unnecessary barriers to evaluation and treatment for children in need of NPT; and processing problems and delays that result in unnecessary barriers to evaluation and treatment.

Implementation Action Steps: The Division of Insurance (Division) should issue a Bulletin for insurance companies under the Division’s regulatory domain clarifying Neuropsychological Testing as a medical benefit for diagnostic, baseline and follow up of disorders that meet medical necessity criteria. In the Bulletin, the Division should direct health plans to follow section 207A of Ch. 224 of the Acts of 2012 and use standardized prior authorization forms for NPT and render decisions on prior authorization as directed by law.

In addition, the Division should require uniform standards for all insurers, including:

- Credentialing psychologists and neuropsychologists who administer NPT as medical and mental health providers. Make these names readily accessible to insurance personnel, so parents are not told that a provider is “out of network” or not on the insurance panel;
- Consistent/ uniform prior authorization forms and standards. The process should be similar to that used for any other medical study or specialist visit; and,
- Authorizations of adequate hours, based on a clinician’s professional judgment, to administer, evaluate, integrate findings, and follow up with families.

6. Alternative payment systems must include quality and financial measures of behavioral health integration. Whenever possible these measures should reflect some uniformity across integrated risk bearing provider organizations so that the long-range goal of sharing best practices and determining which models are successful can be done on the basis of meaningful comparisons.

Rationale: In order to promote and support behavioral health integration among alternative payment systems, quality and financial measures that assess the level of the integration, and its ability to impact and improve health outcomes for individuals with medical and behavioral co-morbidity, should be part of the model.

Implementation Action Steps: All alternative payment models should include measures of quality, health outcomes and cost effectiveness, in both the short-term and in the long-term. Quality measures should include outcome in addition to process measures. They should reflect the goals of the service delivered and the goals of the treatment plan. Outcomes measures based on standardized tools that have been developed to assess improvement in recovery should be included, e.g., Milestones of Recovery (MOR) Scale⁵⁴; Recovery Measurement Tool (RMT) as well as to the degree services are recovery-oriented. Those alternative models must include some measurement of behavioral health integration and the outcomes expected from a well-integrated care setting, including process and outcome measures, including the impact on medical – behavioral co-morbidity.

Measures must be valid, reliable and non-onerous, and available for all services and levels of care to the extent such measures exist. As much as possible, measures should be standardized and aligned with other large measure sets such as those identified within the Affordable Care Act, by the Joint Commission and Healthcare Effectiveness Data and Information Set (HEDIS) or overall Massachusetts health quality initiatives. Uniformity of measures would assist in the ability to determine best practices. The Department of Mental Health, Department of Public Health, and the Health Policy Commission should strive to develop recommendations, with input from providers and people with lived experience, as well as other stakeholders and experts, on a set of uniform measurements.

Financial measures should include long term measures on the cost outcomes of integration, including explicitly the effect on the medical-behavioral comorbidity of the population. They should also include the impact of behavioral health services on short

⁵⁴ <http://www.milestonesofrecovery.com/>

and long-term physical health care costs. In addition, the outcomes measures should be monitored over time to assess any unintended consequences.

7. Alternative payment systems should be funded adequately to support insured populations, must be transparent and must prohibit incentives to limit access to behavioral health care. Provisions for gain-sharing with integrated risk bearing provider organizations must include all providers, including behavioral health.

Rationale: Integrated behavioral health care can be cost effective. One study found that reimbursing primary care clinics for up to 10 mental health visits and 20 substance use visits per year resulted in a 57 percent decrease in inpatient psychiatric days per thousand days and a 12 percent decline in emergency room visits within the treatment group.⁵⁵ In addition, integrated behavioral health care can reduce the cost of medical care. For example, treating depression among individuals with diabetes has been found to reduce the overall cost of diabetes care.⁵⁶ Those who provide integrated behavioral health services need to be recognized for their contribution to decreases in costs by ensuring the opportunity to gain in any shared-savings programs within integrated care settings.

While behavioral health providers should have the opportunity to benefit from any shared- savings programs, financial incentives within alternative payment systems should promote and not inhibit access to quality care. In the 1990's, managed care organizations, which had financial incentives to keep costs under their capitation payments, earned a reputation for keeping their costs low by denying necessary care. To protect the public, financial incentives under alternative payment arrangements should be monitored closely to ensure that they do not impede best practices and that they are tied to quality, not just cost. Individuals receiving services also deserve to know under what financial incentives their providers operate.

Implementation Action Steps: Alternative payments to providers must have sustainable funding that takes into account the rate of reimbursement under non-integrated fee-for-service models, includes a risk adjustment for the patient population served, and allows for flexibility in the types of services delivered in order to meet patient and family needs. Payments should promote access to behavioral health services, as appropriate. Any shared savings or gain-sharing must include the return to behavioral health providers of an explicit portion of the savings that accrue to either behavioral health or medical budgets as a result of integration. Integrated systems' gain

⁵⁵ CMSP Behavioral Health Pilot Project – Brief Findings Summary. The Lewin Group. 2011

⁵⁶ Katon, W et al. "Cost effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression." *Diabetes Care*. 29: 265-270, 2006.

sharing including those of primary care physicians should include meaningful and significant measures of integration and improvement in behavioral health measures in addition to traditional measures of medical care. Bonuses or outcomes for alternative payment arrangements must be based on outcomes of progress towards healthy development, recovery and wellness, and the quality of care provided. Financial incentives to providers must be transparent to the public and monitored overtime to assess any unintended consequences.

8. Commercial plan medical necessity should be transparent and expanded to include payment for services that are designed to assist individuals attain or maintain functioning, such as recovery and transitional support services, residential recovery homes for persons with substance use disorders, and funding for long term services and supports, rehabilitation and support.

Rationale: A broader definition of medical necessity is in keeping with the ten components of recovery published by SAMHSA as an outcome of the New Freedom Commission on Mental Health. Such a definition would protect the reimbursement of services and supports by peers working to assist persons in their roles as wellness, job, and life coaches, which optimize their recovery and wellness. It would also create an opportunity for peers to work as personal care assistants. Some Task Force members raised concerns that this expansion may divert needed clinical funds to non-clinical interventions and that existing services, such as vocational rehabilitation already exist and do not need to be completely recreated.

In addition, portions of Chapter 224 such as parity monitoring, external appeal to the Office of Patient Protection (OPP), behavioral health integration and transparency of cost and quality are to be implemented currently; however, their implementation requires access to the medical necessity and utilization review criteria in order to be effectively implemented.

Implementation Action Steps: Section 199 of Chapter 224 of the Acts of 2012 requires the public disclosure by insurers of utilization review criteria. Task Force members believe that these criteria are used by payers to determine the medical necessity of services, and hence relate directly to access to healthcare. The release of these criteria is set for October 1, 2015. The Task Force recommends an immediate release of this information to assist in behavioral health integration, including assisting providers in knowing which conditions will be covered under health insurance. Transparency of medical necessity criteria and protocols is also necessary to the oversight of parity.

In addition to the release of commercial medical necessity criteria and protocols, there should be an expansion of Massachusetts' Medicaid medical necessity definition to be

closer to Michigan's Medicaid definition of medical necessity, which includes: "Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment [which are]: Designed to assist the consumer to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity." Michigan received a waiver from the Centers for Medicare and Medicaid Services (CMS) to implement this definition.

9. There should be no prior authorization required by insurers for admissions to inpatient psychiatric or inpatient detoxification facilities, or for Clinical Stabilization Services.

Rationale: Prior authorization requirements for behavioral health patients who need intensive levels of service as determined by the treating health care provider raise the specter of violations of federal and state mental health parity laws, and for emergency medical conditions – including behavioral health emergencies – of EMTALA. Task Force members note that while there may be some basis for such requirements for elective procedures, federal and state parity law clearly state that insurers are required to treat behavioral health patients no more restrictively than medical-surgical patients. Patients who are deemed medically appropriate for intensive levels of mental health and/or substance abuse services along the continuum of care have already undergone an evaluation and determination by the treating healthcare provider that the patient has a serious condition requiring an intensive level of care. Such patients should be treated no differently from any patient suffering from a serious medical condition (e.g., pneumonia, acute cardiac condition, stroke, trauma), for whom there is no requirement that the patient or provider seek prior authorization to provide the necessary intensive level of care. However, both public and private health plans require additional authorization for inpatient and step-down levels of care for serious mental health and substance abuse conditions. Therefore, this recommendation proposes that the requirement for prior authorization for inpatient and step-down mental health and/or substance abuse services be removed by all insurers, including MassHealth. The recommendation is not meant to change the role of Emergency Service Providers (ESPs) in helping to determine diversionary levels of care nor is it meant to eliminate a pre-screening prior to an involuntary psychiatric admission.

Implementation Action Steps: The Task Force recommends elimination of payer practices requiring prior authorization for coverage of inpatient and step-down level of services for the care and treatment of mental health and substance abuse services that are not imposed on equivalent physical health care services through the adoption of statutory, regulatory or contractual provisions as necessary to accomplish this

recommendation. Some Task Force members expressed concern that elimination of prior authorization could result in post-admission denials of coverage. These members urged that implementation of this recommendation include protections for providers, particularly inpatient providers, who accept patients based on the referring clinician's determination of medical necessity. Although not all Task Force members support the requirement of assessment by an Emergency Services Program (ESP), as is currently in place for MassHealth members, the Task Force does recognize the importance of assuring that alternatives to hospitalization, especially involuntary hospitalization, are fully explored and made available where appropriate. Whatever form this process takes, the Task Force recommends that it not be in the nature of prior authorization.

As part of this discussion, some members of the Task Force voiced concerns about the number and frequency with which involuntary psychiatric admissions occur. They are concerned that without any oversight of the inpatient psychiatric admission process more involuntary admissions will take place. Instead of eliminating prior authorizations, these Task Force members recommended a process whereby advanced directives would be required for all individuals enrolled within a risk-bearing integrated provider organization in order to be referenced prior to any admissions. However, the majority of Task Force members disagreed with this notion, noting that the process described would be difficult to achieve. To ensure that elimination of this barrier does not inadvertently lead to instances of unwarranted involuntary admission, Task Force members agree that the Commonwealth should undertake a public information campaign to increase awareness about the use of advanced directives and other alternative programs and services that promote care in the least restrictive setting.

How current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high-quality behavioral substance use and mental health outcomes.

10. The Massachusetts Department of Public Health (DPH) should expand its current efforts to review regulations to identify and remove barriers to integration, and MassHealth should undertake a similar process to review its regulations to identify and remove barriers to integration, such as provider and site specific payment structures and payment equity.

Rationale: The Task Force commends the Department of Public Health for setting up a system to allow for a multi-agency review of regulations. In that review, DPH found one of the largest barriers facing primary care practices is the inability to bill for same-

day visits, that is, reimbursement for a primary care visit and behavioral health visit on the same day. This, in addition to other MassHealth regulations, is a barrier to the integration of primary and behavioral health care. The Association of Behavioral Healthcare (ABH) and the Massachusetts League of Community Health Centers (MLCHC) outlined what they considered to be DPH and MassHealth regulatory barriers. Summaries of both are provided in Appendix F.

Implementation Action Steps: DPH should be encouraged to continue its internal high-level review of regulations. It should begin to develop recommendations on how to overcome the most common barriers faced by primary care providers who are attempting to integrate with behavioral health providers. In addition to removing barriers, DPH, in concert with MassHealth, should consider the financial impact of regulatory changes and the Legislature must ensure adequate funding to support the time and effort required to promulgate regulatory changes.

In order to promote integration, MassHealth should allow for the reimbursement of behavioral health care and physical health care on the same day. This can help facilitate a smooth hand-off and ensure continuity and coordination of care. In addition, MassHealth should activate its fee-for-service billing codes for brief assessment and intervention services, using the federally-approved Health and Behavior codes.

Task Force members also recommend a number of related changes to MassHealth reimbursement, including:

- Current procedural terminology (CPT) codes as recognized by the AMA and CMS should be reimbursed regardless of which licensed discipline provides the service, as long as the service is in their statutory scope of practice.
- Massachusetts should increase its Medicaid reimbursement to equal Medicare payment rates, as is available under the ACA for primary care physicians and other specialty providers.⁵⁷
- MassHealth should reimburse all behavioral health CPT codes, including the following codes which at present are inconsistently reimbursed despite the importance of these services to integrated care: diagnostic evaluation with medical services (90792), crisis (90839 and 90840), family therapy without patient (90846), multiple family group therapy (90849), evaluation of records (90885), preparation of report (90889), new (99201-99205) and established (99211-99215) office care, initial (99221-99223) and

⁵⁷ While the ACA does allow for enhanced rates for physicians to meet current Medicare payment rates, this provision of the ACA has not been implemented to date, even though the legislation called for implementation for a two year period beginning on January 1, 2013.

subsequent (99231-99233) hospital care, office consultation (99241-99245), inpatient consultation (99251-99245), emergency department visit (99281-99285), interactive complexity (90785) codes, and all psychological and neuropsychological assessment codes and health behavior codes.

- MassHealth should allow psychologists to provide services to the full extent of their statutory scope of practice.
- Providers of behavioral services for integrated medical-behavioral care and for health promotion and behavioral factors in physical disease management should be able to utilize all diagnostic codes in the ICD and not be forced to assign inappropriate behavioral health diagnoses.
- When behavioral health providers are co-leading a medical group visit with a medical provider, both providers should be able to receive reimbursement for such a group to encourage this type of collaboration, not just one-on-one interventions.
- All payers should reimburse for 2-3 hours of 96116 (brief neurocognitive assessment) by psychologists. Some currently do and others do not. This is a cost-effective option for patients who may need more than just a cognitive screen by their PCP, but less than a full neuropsychological battery.
- Medicaid should develop a cross walk between the DC: 0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition) to the DSM-V for use in seeking payment for services for children from birth to five years of age. Mental health clinicians treating young children and their families utilize DC:0-3R for diagnostic guidance, yet cannot use these codes for billing purposes. Instead, they are required to bill under generic codes that do not fully reflect the treatment they are providing. A tool such as a crosswalk is needed to link DC: 0-3R with the DSM, in order to standardize diagnosis and to increase transparency between clinicians, administrative staff, and payers.

11. Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day. Allow for brief intervention services to be billed before a full assessment is completed.

Rationale: When a primary care provider identifies a potential behavioral health disorder, individuals are more likely to receive recommended follow-up care or referral visits if they occur on the same day as the initial visits through a “warm hand-off” or

personalized introduction by a primary care provider to a behavioral health provider.⁵⁸ Identifying behavioral health disorders and treating them prior to a crisis situation may provide significantly improved outcomes and reduced overall spending. This recommendation proposes that prior authorization for initial behavioral health visits be removed by all insurers.

Implementation Action Steps: The Task Force recommends that MassHealth⁵⁹ and other payers adopt a policy limiting insurers' abilities to require prior authorization for initial behavioral health visits.

12. Quality and outcome measures should be developed that consider the impact of payment methodology on caseload numbers; organizations that are responsible for integrated behavioral health services should be held accountable for quality and outcome measures that are caseload sensitive.

Rationale: As alternative payment methodologies are being developed, it is important to consider the unintended consequences of certain population-based methodologies, such as global payment, on quality of care. Some argue that global payments reward providers for volume by incentivizing them to have higher caseloads. One study suggested that there is a link between high caseloads, the time spent with the person receiving services, and the quality of care.⁶⁰ However, in many alternative payment arrangements, quality or outcome standards must be achieved in order to share in savings or receive bonus payments.⁶¹ For example, the 2012 NCQA ACO Standards and Guidelines require that risk-bearing provider organizations ensure the availability of practitioners who provide primary and specialty care by requiring the provider organization to establish quantifiable and measurable standards for the number and type of each practitioner providing care, the geographic distribution of those providers and analyzes the provider performance against the standards and patient experience with the availability of those providers. Quality measures could be developed to assess compliance with this standard. Without standardized quality and outcome metrics focused upon behavioral health, it is possible that the incentive for providers to carry unnecessarily high caseloads may still exist. High caseloads also do not account for new work required in an integrated setting – including case collaboration with primary care providers, collateral contacts with families, or individual support systems and accurate

⁵⁸ Mauch, D., Kautz, C., and Smith, S., "Reimbursement of Mental Health Services in Primary Care Settings" U.S. Department of Health and Human Services, Substance Abuses and Mental Health Services Administration, February 2008.

⁵⁹ MassHealth does not require prior authorization for the first twelve visits. After that, authorization for additional visits is required.

⁶⁰ H. Balkrishnan et al. "Capitation payment, length of visit, and preventive services." *Am J. Managed Care.* 332-340 (2002).

⁶¹ Robinow, A. "The potential of global payment: insights from the field." *The Commonwealth Fund.* February 18, 2010.

record keeping. Therefore, the Task Force recommends that quality and outcome measures be developed that consider the impact of payment methodology on caseload numbers and that organizations that are responsible for integrated behavioral health services be held accountable for those quality and outcome measures.

Implementation Action Steps: As a first step to implementation, the Health Policy Commission should convene an independent body of experts to include, but not be limited to behavioral health providers, provider organizations, payers, and persons and families with lived experience to research and study the implications of population-based payment methodologies on the caseloads of behavioral health providers. Research should include the examination of other caseload standards in the health care field, especially those that may have been developed or used by behavioral health providers.

As part of its research, the independent body of experts should look to existing formulas utilized by the Center for Health Information and Analysis (CHIA) under Chapter 257 of the Acts of 2008 in the development of unit rates for EOHHS purchase of service (POS) contracts. These formulas take into account expected types of interventions and desired outcomes, types of providers delivering the intervention and caseload as determined by utilization as well as any regulatory and/or contractual requirements in certain care settings purchased by EOHHS agencies. Such formulas are utilized, for example, in all contracted and licensed inpatient and outpatient addiction recovery programs operating under the auspices of the DPH, Bureau of Substance Abuse Services (BSAS). It is expected that caseload standards would vary by behavioral health provider type and care setting type. In addition, different factors might need to be incorporated into formulas for children and adult caseloads. The standards need not result in a single ratio, but in a range and should be subject to modification over time.

The quality and outcome measures should be encouraged to be used by integrated risk-bearing organizations to ensure their capacity to provide high quality behavioral health care. As part of the certification process, risk-bearing organizations should be required to report on arrangements with behavioral health providers (exclusive vs. non-exclusive), the ratio of behavioral health providers to enrollees (broken down by specialty and enrollee type) and geographic accessibility to those providers. Data should be collected relative to the impact on the health and robustness of the provider network within these new care models with particular attention to the impact on the network's ability to meet the clinical needs of the population served.

13. Ensure full and appropriate funding for MCPAP based on a contribution from commercial insurers for the percentage of their members who benefit from the program.

Rationale: The Massachusetts Child Psychiatry Access Project (MCPAP) provides broad access to child psychiatry consultation and has become the statewide solution for the current and projected shortage of child psychiatrists, which in the past led to significant problems for families to access child psychiatry. On an annual basis MCPAP provides assistance to 80 percent of the Commonwealth's primary care practices serving 98 percent of the state's youth. In FY 2013, MCPAP is projected to serve over 10,000 youth with over 20,000 encounters. It has improved provider satisfaction with their ability to access psychiatric care for their patients and has achieved high rates of parent and family satisfaction. MCPAP has become a model for the country, with over 25 states implementing similar consultation programs. It has received national recognition in the literature^{62,63} and by the Agency for Healthcare Research and Quality.⁶⁴

MCPAP provides its services to any PCP, regardless of a child's insurance source. Sixty percent of youth served have commercial insurance and 40 percent of youth served have public insurance. Today, one hundred percent of its funding is supported by the Massachusetts Department of Mental Health.

Implementation Action Steps: A "user fee" should be assessed on commercial insurers, commensurate with providers' use of MCPAP.

As integrated risk bearing provider organizations become established, their global payments should be calculated to support their providers' continued use of psychiatric consultation. MCPAP provides a cost-effective statewide resource that should continue to be leveraged.

14. Expand the role and fund the capacity of communities to identify local needs and promote health and wellness and other prevention programs.

Rationale: Communities play a unique role in their ability to change the systems and organizations that impact people's lives every day, including the schools, worksites and the community itself. The community in which a person lives can have profound

⁶² The Commonwealth Fund. Case Study: High Performing Health Care Organization: The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care, March 2010;

⁶³ Barry Sarvet et al. "Improving access to mental health care for children: The Massachusetts child psychiatry project. *Pediatrics*, Volume 126, Number 6, Dec 2010

⁶⁴ "Regional teams enhance ability of primary care clinicians throughout Massachusetts to serve children and adolescent with mental health issues." *Agency for Healthcare Research and Quality*.

<http://www.innovations.ahrq.gov/content.aspx?id=3058&tab=1>

impacts on his or her medical and behavioral health outcomes. It is incumbent upon the communities and community leaders of Massachusetts to devote attention to prevention and the promotion of health and wellness.

Chapter 224 created a Prevention and Wellness Trust Fund (the Fund), administered by DPH. All activities paid for by the fund must support Massachusetts' goal to meet the health care cost growth benchmark and have at least one of the following functions: reduce the rates of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and build evidence of effective prevention programming. The Commissioner of DPH must award at least 75% of the fund each year through a competitive grant process to community-based organizations, public and private sector health care providers, health plans, municipalities, and regional planning agencies. The Commissioner can give priority to proposals in geographic areas with high need.⁶⁵

Implementation Action Steps: Funds from the Fund should be earmarked for programs that target particular high-risk groups and programs that intervene with those already involved in high risk behaviors. As a first step, DPH should take a strategically long-term approach to managing this Wellness Fund by investing, in part, in children's well-being. Funds should be distributed toward childhood prevention strategies of exposure to toxic stress and adverse childhood experiences (ACE). The Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations. DPH could utilize ACE data, along with other sources, to guide its grant-making and leverage existing initiatives that incorporate a recovery and trauma-focus into service delivery.

Distribution of funds to promote wellness in children and families should be prioritized to grantees who demonstrate the capacity to use evidence-based or emerging practices such as the Strategic Prevention Framework, a five step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span.⁶⁶ It has been designed to assist communities in identifying specific prevention needs and tailoring prevention messages to those needs.

At the same time, there must be investment in wellness activities that are culturally and linguistically sensitive and competent, and designed to address recognition and

⁶⁵ Anna Gosline and Elisabeth Rodman "Summary of Chapter 224 of the Acts of 2012." *Blue Cross Blue Shield of Massachusetts Foundation*. September 2012

⁶⁶ Substance Abuse and Mental Health Services Administration. Strategic Prevention Framework. <http://www.samhsa.gov/prevention/spf.aspx>

integration of physical and behavioral health at the level of routine care, so that issues are recognized and treated before they become severe. These activities would have the double advantage of mitigating health care costs with early intervention and diminishing the stigma of mental illness and substance use disorders that has been discussed elsewhere in this report. For example, funds could be used to develop and research innovative strategies to provide integrated and behavioral health care, such as the expansion of peer run providers and the expansion of training of peer providers throughout the Commonwealth, or to expand the use of emotional CPR (eCPR) in the workplace and in schools.

The Fund's investments should be evaluated for return on investment (ROI).

C. Privacy

What are the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable health records?

There are differences in privacy concerns across populations, but as noted in the background section above. There are particular concerns regarding the use of information from behavioral health treatment both within and outside of the health care system, particularly in schools and the legal system. There are numerous state and federal privacy laws that provide parameters to what can and cannot be shared. For example, the Health Insurance Portability and Accountability Act (HIPAA) together with numerous provisions of Massachusetts law provides broad protection of individually identifiable health information. In addition, the Federal Drug and Alcohol Confidentiality Law (42 CFR Part 2) provides additional protection relating to individuals with or who seek treatment for alcohol or other substance use problems. 42 CFR Part 2 applies broadly to any program that provides alcohol or drug abuse diagnosis, treatment, referral for treatment or prevention and is "federally-assisted" and requires specific written authorization by an individual to share information on substance use, diagnosis and treatment at the point of each potential disclosure.

The Task Force recognizes that stigma and discrimination are significant problems for individuals with behavioral health disorders. The recommendations below aim to balance stigma and consumer choice, current federal privacy laws, and the importance of providers understanding the totality of a patient's needs in order to provide optimal care and obtain optimal health results.

15. There must be a respectful equilibrium, or balance, between what information providers need to deliver quality care and what the individual needs to seek and receive appropriate care.

Rationale: Electronic health records (EHRs) are a potentially useful tool in providing effective, efficient, integrated and safe health care. Electronic health records are broadly defined as longitudinal electronic records of patient health information generated by one or more encounters in any care delivery setting and can include information such as: patient demographics, diagnosis progress notes, problem lists, medications, vital signs, past medical history, diagnostic results and more.⁶⁷

Since the majority of mental health and substance use needs are addressed within the primary care practices, EHRs, and information sharing generally, are especially critical for a primary care physician to provide safe high quality care to patients, particularly in managing the care of these complex patients. EHRs can assist primary care teams in providing important components of primary care, including complex care management, medication management, reminders for timely care (like administration of screening tools), and warnings for adverse interactions, outcome reports and follow-up lists for a population of patients. For example, physicians in Massachusetts with access to electronic problem lists performed better on quality measures related to depression (as well as other measures) compared to physicians not using electronic health records.⁶⁸

However, barriers to including behavioral health information within the electronic health record exist – including lack of standardization for inclusion of behavioral health care processes within the electronic record, and important privacy and confidentiality concerns. As reported by both individuals and family members, as well as providers, confidentiality is a basic requirement of persons seeking behavioral health services and the lack of such confidentiality may result in individuals avoiding care or being less forthright while engaging in services. Individuals with behavioral health disorders and some providers are also concerned by the impact of real and perceived stigma on the quality of integrated health care. The Task Force heard from individuals with lived experience that were inappropriately treated for physical health conditions based on a provider’s knowledge of a behavioral health diagnosis. A new survey of providers found that providers, including mental health providers, view patients with serious mental illness more negatively than those without and that these attitudes impact treatment decisions, including referrals.⁶⁹

⁶⁷ Healthcare Information Management Systems http://www.himss.org/ASP/topics_ehr.asp

⁶⁸ EG Poon et al. “Relationship between use of electronic health record features and health care quality: results of a statewide survey.” *Medical Care* March 2010, Volume 48, Issue 3, pp 203-209.

⁶⁹ Jeffrey, S. “Psychiatrists not immune to mental health bias.” *Medscape*, May 21, 2013.

The Task Force spent much time deliberating the issue of privacy and balancing the need to protect individual rights and consumer choice with the clinical need for information sharing to provide high quality integrated care. These privacy issues exist in the absence of electronic health records but become more pressing as more providers utilize electronic health records that include most information about a patient.

Studies have shown that individuals with mental health conditions die 25 years earlier due to largely preventable and treatable physical health conditions⁷⁰ and that having appropriate access to all pieces of an individual's health history could improve those outcomes. In addition, primary care physicians report that the lack of (and difficulty of obtaining) information from an individual's behavioral health record can lead to adverse consequences on the health and outcomes of an individual. As an example, not knowing which medications a patient may be taking or what conditions they live with, primary care physicians might risk prescribing medications that may negatively interact with existing medications or produce side effects that exacerbate a behavioral health issue.

Implementation Action Steps: There was general agreement that, except in emergency situations where the individual is unable to give consent, persons receiving care should have the authority to determine with whom that information is shared. There was also general agreement that information sharing should be categorized into tiers, and each tier should have a set of rules governing the disclosure of information within the tier, including provisions for patient choice of opt-in (individual affirmatively agrees to share information across providers) or opt-out (information is shared across providers unless the individual specifically requests for it not to be shared) of standard disclosure practices.

The Task Force agreed on three categories of bi-directional⁷¹ information sharing:

- Tier 1: medication, lab results and mental health diagnoses
- Tier 2: all other behavioral health information not in Tiers 1 or 3, for example, treatment plans, functional and risk status (e.g., suicidal ideation), psychological and neuropsychological assessments, stress factors, community supports, and substance use diagnoses
- Tier 3: diagnostic evaluation and treatment notes

A majority of the Task Force agreed that Tier 1 information be shared with other treating providers within the confines of existing law without prior written consent, which is the

⁷⁰ Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006.

⁷¹ One Task Force member noted that medical providers should not restrict access to any information related to the behavioral health needs of the patient to a behavioral health provider.

case for other specialties.⁷² The individual would have the ability to revoke the sharing of information at any time. A minority of Task Force members voiced strong opinions that, due to stigma, sharing of Tier 1 information presents a documented risk of denial of physical health care and may discourage individuals from seeking behavioral health care, and that informed consent should be sought prior to the sharing of this information. While all Task Force members agreed that stigma among medical and behavioral health professionals negatively affects care, the majority felt that the problem of stigma needs to be addressed separate and apart from the benefits of integrated information sharing and that greater information sharing may help to reduce the burden of stigma by not continuing to create two different systems of care.

The Task Force unanimously agreed that Tier 3 information does not need to be shared to appropriately treat an individual and should only be shared if the individual affirmatively agrees to its sharing through the execution of a signed standardized release of information form and an informed conversation with their provider prior to the release of information.

Task Force members engaged in meaningful discussion of the benefits and concerns of how information in Tier 2 should be shared, but remained split on whether the category of information should be opt-in or opt-out. Given that the Task Force was not able to reach consensus, we recommend continued discussion of the appropriate level of information sharing for Tier 2. Task Force members raised viable arguments for both opt-in and opt-out in Tier 2. To further this discussion, it will be helpful to collect data on individual patient choice in terms of information sharing under an opt-in model, and whether the individual would have objected to this information being shared under an opt-out provision. This could potentially be included as part of the standardized forms to be developed.

One particular discussion among Task Force members centered on whether psychological and neuropsychological assessments should be in Tier 2 or Tier 3. Some Task Force members noted that the results of these assessments were very important to medical providers and barriers to reviewing the information should be mitigated. However, other Task Force members felt that the privacy of the personal nature of what is contained within a psychological and neuropsychological assessment must be maintained at the strictest standards given in Tier 3. The Task Force recommends continued discussion of the particulars of Tier 2 information sharing in other forums, including the subcommittee of the Health Policy Commission recommended as part of Recommendation #27.

⁷² As noted, special rules apply to substance use information under 42 CFR Part 2. In addition, some mental health information is further restricted pursuant to G.L. ch. 123 § 6.

A standardized release of information form needs to be created to accommodate the different tiers of information sharing. For Tier 1, the form should clearly state the potential risks as well as the benefits of not sharing this information. For Tiers 2 and 3, a standardized release form with an opt-in provision should be created that clearly states the potential risks as well as benefits of sharing this information. The form must comply with the provisions of 42 CFR Part 2, as discussed above.

In addition to the form and perhaps more important, Task Force members felt it was important that providers have a detailed conversation with individuals about what information will be shared, with whom, and the implications for doing or not doing so. Person-driven healthcare should be supported by ensuring that individuals receiving care are active participants in all phases of their care and that the records document this participation: from a description in narrative as well as diagnostic terms, to the formulation of goals, to the recording of progress, to the evaluation of outcomes.

Task Force members agreed that in emergency situations, it was essential that full medical records be available to properly assess diagnoses, medical and behavioral disorders and risks to patients from any and all possible disorders in accordance with federal and state laws.

In order to do business with Massachusetts providers, the Legislature should require EHR vendors to include certain elements to support affordable and interoperable behavioral health records and the granularity to make certain information private, particularly treatment notes. The Task Force recognizes that many providers have implemented various EHRs. Vendors should advise where possible system modification could occur to allow for increased granularity to only show certain information based on an individual's decision to opt-in or out of information sharing.

Inpatient psychiatric providers should be required to communicate in a timely fashion with integrated risk bearing provider organizations information about the date of admission, the reason for admission, medical-behavioral conditions, and in a timely fashion prior to discharge, the discharge plan and hospital record, at a minimum.

As noted above, one of the unique factors with respect to children exists in the relationship between healthcare providers and school-based health services. Exchange of information between the two is both critical and challenging. Recent conversations among DMH, the Department of Children and Families (DCF), and parents indicate that parents might be comfortable sharing information about a child's behavioral health issues/care with a school as long as it is for a specific purpose; however, they don't want to share the entire family history. In addition, there are legal issues regarding consent to

the sharing of information by parents and/or young people that must be resolved. Consent by the parent(s) may be sufficient in one context, but consent by the parent and consent/assent by the young person may be required in other circumstances. The MA Child Health Quality Coalition's Communication and Confidentiality Task Force are identifying issues impacting communications and confidentiality across the Coalition's stakeholder groups as well as resources that can help address those issues.

16. Certification requirements for integrated risk bearing provider organizations should include training of health care providers on privacy and confidentiality and such organizations should be required to have a privacy officer.

Rationale: Given the importance of privacy within integrated settings, the Task Force believes it is essential that integrated risk bearing provider organizations be required, as part of their certification, to conduct training on privacy and confidentiality. In addition, these organizations should be required to include a privacy officer to monitor its ability to meet privacy and confidentiality requirements, and obtain feedback from both individuals and providers of the impact of the privacy requirements.

Implementation Action Steps: The Legislature should direct the Division of Insurance (DOI) to develop and consider privacy requirements consistent with Task Force recommendations, as well as policies, procedures and training requirements as part of its review and certification of an integrated risk bearing provider organization. The DOI should provide sample training materials upon request.

17. Massachusetts should establish criteria in statute or regulation that would limit the circumstances under which a behavioral health care provider can restrict an individual's access to his or her records to those situations that present a clear and articulated harm.

Rationale: Electronic health records are often hailed for their ability to rapidly transmit medical information to a vast array of providers with a click of the mouse. Unfortunately, this means that misinformation can be spread just as rapidly.⁷³ While

⁷³ There is reason to be concerned about errors in electronic health records. A pilot study found that inaccuracies in medication lists were reported in 51% of records reviewed with 32.1% of all medications being inaccurately recorded. Tse J, You W. "How accurate is the electronic health record? - a pilot study evaluating information accuracy in a primary care setting." *Stud Health Technol Inform.* 168:158-64. Royal Melbourne Hospital Clinical School, The University of Melbourne, Parkville, Victoria. 2011.

Massachusetts law grants an individual broad access to his or her physical health records, it does permit withholding at least portions of behavioral health records, under certain circumstances, if the provider determines that release of such records could cause harm to the individual or others. However, existing statutes and regulations do not provide clear guidance on the standards under which this authority may be exercised, and to what extent such records may be withheld.

Implementation Action Steps: The state should adopt legislation reaffirming a broad right of access, establishing narrow criteria for withholding behavioral health records, and documentation of the rationale for the failure to provide an individual with access to his or her own records. Such criteria should be applicable to all covered entities under HIPAA. The legislation should make it clear that only those parts of the record that meet the criteria established may be withheld, and that, to the extent possible, a summary of the withheld information must be provided. Persons denied records should be given notice of why (the individualized documentation in the record) and their avenues of internal appeals and external complaints. In addition, a speedy means of appealing the denial of records should be mandated and, if possible, an external complaint procedure (other than the federal Office of Civil Rights (OCR)) should be established. Finally, a meaningful way of addressing errors in electronic health records must be developed (both corrections and, upon request of the patient, distribution of those corrections to parties to whom the erroneous records had been provided).

D. Education and Training

How best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services.

18. To the extent possible, require Massachusetts-based schools that prepare students for careers in medicine, nursing and allied behavioral health professions to educate students about behavioral health and related medical care issues.

Rationale: Many Task Force members expressed concern that providers do not receive appropriate education or training while in school to prepare them to treat individuals and families with lived experience or to begin to address stigma issues. Many Task Force members believed it was important to enhance the current school curricula to incorporate training on: providing trauma-informed care; behavioral health issues as a treatable disease; the concepts of recovery and wellness; and how to identify, treat and refer individuals with behavioral health challenges and their families to appropriate levels of behavioral health care.

However, some Task Force members recognized that school curricula are often dictated in large part by national standards and it may be difficult for Massachusetts to require schools to provide this education. Further, some believed that this recommendation would not be implementable given the existing tension between national standards and other curricula setting bodies. One Task Force member expressed concern that if integration is successful, more people may need health care services, placing a burden on the capacity of the system to address the clinical needs of individuals and that the recommended training may take too much time away from service delivery. Ultimately, this recommendation is not meant to have a chilling effect on the requirements for providers, but the Task Force recommends that to the extent possible, Massachusetts-based schools that prepare students for careers in medicine, nursing and allied behavioral health professions be required to educate students about behavioral health and related medical care issues in an effort to prepare them to work in an integrated setting.

Education and training is important for all provider types, because individuals with behavioral health issues present in many settings for many different services that may either be impacted by or impact a behavioral health condition. Integrating behavioral health care and physical health care allows for diagnosis and treatment of behavioral health factors that contribute to development of chronic health conditions such as obesity, cardiovascular disease, Hepatitis C and diabetes and that interfere with patients' engagement with recommended treatment and recognition of common chronic medical disorders in behavioral health settings. People with a range of psychiatric, substance use or cognitive symptoms are at increased risk for not adhering to prevention or treatment plans. This includes individuals who have severe and chronic mental illness and those who have cognitive disorders as a result of neurologic conditions, along with the much larger group of people who have conditions such as depression, anxiety, or ADHD or who have ingrained or burgeoning unhealthy lifestyle habits.

Implementation Action Steps: To the extent possible, including adopting a requirement for state licensure, or for taking any state-funded support, professional schools or undergraduate schools that prepare future health care professionals (e.g., nursing) must show proof of the following elements as active pieces of its curriculum, whether on its own or included as part of another relevant part of the curriculum.

- Enhanced educational training on behavioral health conditions as often preventable and always treatable conditions that lend themselves to being effectively prevented and treated with evidence based interventions and

- promising practices⁷⁴ depending on the individual's circumstance and age, and particular condition.
- Broad curriculum focused on behavioral health and the importance of its overall integration into the entire practice of medicine.
 - Anti-stigma education and recommend its completion as a graduation requirement, regardless of the provider's focus. As part of that effort, persons with lived experience should participate in the development of the education and should participate in the actual educational sessions to describe their experience with the health system, and how they experience stigma. An example of such training is the National Alliance on Mental Illness (NAMI) *In Our Own Voice*, a unique public education program in which two trained persons with lived experience share compelling personal stories about living with mental illness and achieving recovery.⁷⁵ Other information on mental health recovery, as developed by the National Empowerment Center from SAMHSA's components of recovery from mental health and substance abuse conditions should be offered. There are analogous programs for persons with lived experience who are in recovery from substance use disorders including persons from the MA Organization for Addiction Recovery (MOAR).
 - Training must include provider education of primary care and other medical providers regarding behavioral health screening mechanisms. Screening mechanisms are not diagnostic and training must also include evidence based guidelines on consultation and referral with behavioral health providers for further diagnosis and treatment.
 - Enhanced education of medical and behavioral health providers in common medical disorders and their screening, management and referral options.
 - Enhanced education of primary care providers and other non-behavioral health care providers on the relationship between behavioral health medications to chronic conditions, recognizing that psychiatric medications may bear the risk of inducing chronic conditions.⁷⁶

The Task Force recognizes that this recommendation may be difficult to implement due to the inability to influence the curricula of undergraduate and graduate schools that train future medical professionals. Absent that ability, special financial incentives could be offered to providers who are trained in the items mentioned above. Such financial

⁷⁴ For example, an evidence-based practice may include the use of medication assisted treatment for persons with opiate disorders.

⁷⁵ For more information, see http://www.nami.org/template.cfm?section=In_Our_Own_Voice. Other information on mental health recovery is also available, including information developed by the National Empowerment Center from SAMHSA's components of recover from mental health and substance use conditions.

⁷⁶ Muench J and Hamer A. "Adverse effects of antipsychotic medications." *American Family Physician* 617-622 (2010) and O'Riordan M. et al. "Antidepressant use linked with increased atherosclerosis." *Medscape* April 14, 2011.

incentives could include enhanced reimbursement or loan forgiveness for behavioral health providers with demonstrated certification, where available, or sufficient training and experience in the competencies mentioned above. Alternatively, a Certificate of Excellence program can be established whereby the state awards certification to schools that achieve the above elements of behavioral health integration education. Incentives for achieving excellence in behavioral health integration education could result in certified schools or programs receiving priority recognition for state funding or grants.

19. Develop and fund education and training tools for providers on how to identify behavioral health conditions and co-morbid medical conditions or issues, and treat or refer (as appropriate), recognizing there are a range of solutions and treatments that work, including models that emphasize the value of prevention, models that encourage the healthy development of children, training on recovery models of care, and emotional CPR.

Rationale: As described above, there are opportunities to improve the curricula of undergraduate and graduate schools to more adequately prepare providers to identify or serve individuals with behavioral health conditions. This recommendation mirrors the recommendation to enhance the educational focus on behavioral health conditions and reducing stigma, by enhancing the training available to and required of practicing providers on these issues. Education can and should be provided in a variety of settings using a wide array of tools to educate providers. This is critical to the successful education of our diverse corps of health care providers. A minority of Task Force members expressed concern about this recommendation and those thoughts are reflected in Recommendation #18.

Implementation Action Steps: To encourage providers to participate in continuing education and training programs, the offering of continuing education credits necessary for maintaining a license or gaining a particular certification is an important incentive to make continuing education a priority. Educational opportunities should take many forms, providing a flexible way to allow for health care providers to receive training when they can. Educational materials should be developed in concert with persons with lived experience. Such education and training tools may include:

- Monthly abstracts
- Access hours (similar to MCPAP)
- Lunch seminars
- Trainings delivered by people with lived experience
- Webinars
- Home study programs

- Web-based programs, such as the MA PCMHI Behavioral Health Integration Toolkit and the SAMHSA Training to certify buprenorphine providers
- Integration certificate programs, such as the UMass Center for Integrated Primary Care

As noted above, combating stigma must be a key component of educational efforts. The most effective means to eliminate stigma in the health care system is the inclusion of successful persons with lived experience as colleagues within the delivery system and within care teams.⁷⁷ In addition, we recommend that the state work with advocacy organizations to sponsor educational campaigns to confront ongoing stigma of behavioral health disorders, promote individuals with lived experience and promote that behavioral health issues are treatable. As part of this effort, the state should leverage and promote the National Recovery Month campaign in September to educate providers and people with lived experience on availability for and successful treatment of mental health and substance use issues. The National Recovery Month promotes the societal benefits of prevention, treatment and recovery for mental and substance use disorders, celebrates people in recovery, lauds the contributions of treatment and service providers, and promotes the message that recovery in all its forms is possible.⁷⁸ Similarly, the state should continue to support and leverage National Children’s Mental Health Month each May.

Additionally, to provide ongoing education, the Task Force recommends that the Legislature provide the EOHHS with funding to support the ongoing, public and web-enabled availability of the Behavioral Health Integration Toolkit that was developed by the Massachusetts Patient Centered Medical Home Initiative. The Toolkit is a collection of strategies, training materials and resources that primary care practices can access to assist them in their efforts at integrating mental health and substance use treatment and/or referral in the primary care setting. (A summary of the Toolkit is available in Appendix E).

⁷⁷ See Corrigan P. and Gelb B. “Three programs that use mass approach to challenge the stigma of mental illness.” *Psychiatric Services* 393-398 (2006); M. Hugo. “Mental health professionals’ attitudes towards people who have experienced a mental health disorder” *Journal of Psychiatric and Mental Health Nursing* 419-25 (2001); Pettigrew T and Tropp L.. “How does intergroup contact reduce prejudice? Meta-analytic tests of three mediator”, *Eur. J. Soc. Psychol.* 922-934 (2008); *see also*, Kolodziej M and Johnson B. “Interpersonal contact and acceptance of persons with psychiatric disorders: A research synthesis.” *Journal of Consulting and Clinical Psychology* 1387-1396 (1996).

⁷⁸ National Recovery Month. <http://www.recoverymonth.gov/> SAMHSA.

How best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness

20. Develop and fund continuing education tools, including information on behavioral health disorders as drivers of and barriers to effective treatment of chronic health conditions, and provide access to these tools and other resources for both behavioral health and primary care providers. Require this training as part of state licensure requirements, where appropriate.

Rationale: In concert with the education and training required in the recommendations above, it is important to also include training on the intersection of behavioral health and physical health conditions, as well as the contributions of social context to both. Statistics show this overlap for adults quite clearly. For instance:

- depression is found to co-occur with 17% of cardiovascular chronic conditions, 27% of individuals with diabetes, and more than 40% of adults with cancer;⁷⁹
- smoking is also a major driver of chronic health conditions;⁸⁰ and,
- substance use disorders are associated with increased risk of certain cancers, HIV and Hepatitis C.⁸¹

For children, the issues of concern are more often in reverse: it is the effect of emotional or psychological trauma, or toxic stress, on their physical health over their lifespan into adulthood about which healthcare providers need to be educated, as well as the childhood and adolescent onset of many behavioral health conditions. There is ever-expanding basic science research demonstrating how ongoing stress of sufficient intensity can cause enduring changes in brain maturation across childhood into young adulthood, as well as in circulatory, endocrine, digestive, and neurological functioning. The most compelling evidence of this impact has been produced by the landmark Adverse Childhood Experiences (ACE) study. The ACE Study is a decade-long and ongoing collaboration between Kaiser Permanente’s Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC). It includes 10

⁷⁹ “Mental Health and Chronic Diseases.” National Center for Chronic Disease and Health Promotion, Division of Population Health. Issue brief No. 2, October 2012. Centers for Disease Control and Prevention. Atlanta, GA. <http://www.cdc.gov/nationalhealthyworksites/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf>

⁸⁰ Ehrlich, Emily; Kofe-Egger, Heather; Udow-Phillips, Marianne. Health Care Cost Drivers: Chronic Disease, Comorbidity, and Health Risk Factors in the U.S. and Michigan. Center for Healthcare Research & Transformation. Ann Arbor, MI. August 2010.

⁸¹ See information related to link between alcohol use and cancer from the American Cancer Society at <http://www.cancer.org/cancer/cancercauses/dietandphysicalactivity/alcohol-use-and-cancer>; see also basic information on relationship of drug use and HIV and Hepatitis C at <http://aids.gov/hiv-aids-basics/prevention/reduce-your-risk/substance-abuse-use/>

types of adverse childhood experiences: childhood abuse (emotional, physical, and sexual abuse), neglect (physical and emotional), and family dysfunction (growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, a parental separation/divorce, or a family member incarcerated). Over 20% of respondents experienced three or more categories of trauma, or ACEs. The ACE Study examined the relationship between these experiences during childhood and reduced health and well-being later in life. It showed dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of death.

Sociocultural stressors that accompany the material deprivations of poverty affect adults as well children and are strongly associated with mental health difficulties. Education about the relation of poverty to health concerns and appropriate behavioral health interventions are recommended.⁸²

Implementation Action Steps: As with the training recommended above in Recommendation #19, to ensure that providers participate in training programs, it is essential that continuing education programs offer credits necessary to maintain a license or gain a particular certification. In addition, educational opportunities should take many forms, and should include persons with lived experience and their families in its development and delivery as delineated in Recommendation #3, providing a flexible way to allow for health care providers to receive training when they can.

Additional Education and Training Recommendations

21. Expand the role of individuals and families to participate in, direct or accept responsibility for their care, including in choosing wherever possible from whom among qualified providers to receive their care or the care for their children, and to also select other supports to be involved in planning and care coordination with the providers identified above.

Rationale: A necessary factor in the treatment of behavioral health disorders is the engagement of individuals and their families. Studies show that where there is engagement there is improvement in both behavioral health and physical health issues.^{83,84,85} Individuals and their families are not engaged for a number of reasons,

⁸² Goodman L et al., "Within and beyond the 50-minute hour." *J. of Clinical Psychology* 182-90 (2013). See also, Saren J. et al., "Relation between household income and mental disorders." *Arch. Gen. Psychiatry* 419-427 (2011).

⁸³ James, J. "Health policy brief: patient engagement," *Health Affairs*. February 14, 2013.

⁸⁴ Gawrysiak M et al. "Neural changes following behavioral activation for a depressed breast cancer patient: a functional MRI case study." *Case Reports in Psychiatry*. Volume 2012.

including not seeking care because of the real or perceived stigma of behavioral health disorders, due to restrictive networks that limit the available provider network or restrict access to certain types of providers, or financial barriers. In addition, individuals and families may not engage in care based on inability to choose a provider that connects with them and understands how they feel based on their own lived experience. Finally, there is evidence that engagement is particularly low among underserved and minority populations, suggesting the need for increased emphasis on culturally competent and linguistically appropriate care. Working with individuals and families to identify their preferences and then providing the individuals with the opportunity to choose care that fits with their personal preferences, such as the setting, time of day, and where to receive care, increases engagement and enhances the likelihood that care will enhance personal meaning, satisfaction and quality of life.

Not only is continuity of care with a trusted provider critical to effective care, particularly for youth, generally respecting individual provider preference for a behavioral health care has the potential for lowering costs of care because a good therapeutic alliance improves the likelihood of care being successful.⁸⁶

Implementation Action Steps: Individuals and, where appropriate, their families should be active participants in treatment decisions and in the treatment team. Person-centered care requires such participation, which should be documented in treatment records. In addition, the use of peer supports should be expanded to enable meaningful participation in treatment planning by individuals, as peer supports advocate that individuals take responsibility in their recovery.⁸⁷

The Task Force recommends that the Health Policy Commission, DMH and other policy makers be directed and funded to develop a public education campaign on the benefits of integrated care, including the identification, treatment and available resources for behavioral health disorders, and their co-morbidity with medical disorders and how integration might impact an individual's care. This campaign should utilize a host of community settings, social media, and public service announcements on television and radio. The campaign should be planned and developed with assistance from persons

⁸⁵ Hibbard, J et al. "Do increases in patient activation result in improved self-management behaviors?" *Health Services Research*. 2007 August; 42(4): 1443-1463.

⁸⁶ The therapeutic alliance may be more important than the mode of treatment in determining the effectiveness of care. Safran et al. "Alliance, negotiation and rupture resolution." Handbook of Evidence Based Psychodynamic Therapy. (R. Levy & J. Ablon, eds.) pp. 201, 208 Humana Press 2009.

with lived experience. The message should include the value of peers and family partners as key elements of integration and re-design of health care delivery.

To further the realization of the potential benefits of integrated care, ongoing mechanisms should be established for the engagement of persons with lived experience in the process of healthcare policy development. The use of peer supports who can advocate that individuals take responsibility in their recovery should be expanded.⁸⁸

E. Workforce Development

While the Legislature did not specifically pose a question focused on workforce development, the Task Force makes five recommendations related to workforce as we believe it is essential to address workforce capacity as part of the successful integration of behavioral health and primary care.

22. Require access to behavioral health services, directly or by contract, by a hospital and federally qualified health centers (FQHCs) as part of licensure

Rationale: A goal of any integrated system should be to provide a system of care that improves access to behavioral health care across the spectrum of intensity. Requiring the offering of behavioral health services by licensed providers, either directly or by contract, will help reinforce integration and perhaps assist in expanding access. MassHealth requires FQHCs to have comprehensive services on site or by referral.

Implementation Action Steps: State licensure requirements for hospitals and federally qualified health centers should include the ability to serve the behavioral health needs of members of their communities. In performing its licensing function, DPH should assess whether the provider has the ability to provide care for emergent behavioral health needs as well as routine needs and screening, as appropriate for the care setting. Such services may be provided by the licensed organization or the licensed organization must demonstrate the ability to access the services in a timely manner. In certain circumstances, telemedicine may be an option small licensed organizations can use to fulfill this requirement.

Given the varying sizes of primary care practices, telemedicine will be an important mechanism to support integration. In the absence of increased trained behavioral health providers throughout Massachusetts, small PCPs or those located in non-urban areas may need to access behavioral health consultation virtually. The Massachusetts Child Psychiatry Access Project (MCPAP) provides a successful model for solving this problem for pediatric primary care clinicians by providing them with virtual access, via

⁸⁸ Woodhouse A. and Vincent A. "Development of peer specialist roles: a literature scoping exercise." *Scottish Recovery Network and the Scottish Development Centre for Mental Health*. August 2006.

telephone, to child psychiatry consultation. The Task Force recommends the continued and sustained funding of MCPAP in Recommendation #13 and the expansion of similar models to the adult population.

23. Review scope of practice rules to determine whether they can be effectively and appropriately broadened to provide the care necessary in an integrated environment.

Rationale: In an effort to combat workforce shortage and expand access to behavioral health services, some Task Force members wish to expand the practice rules for certain professionals and to expand reimbursement to match statutory scope of practice in Massachusetts. For example, thirteen states and the District of Columbia have passed independent practice laws for psychiatric clinical nurse specialists. The Institute of Medicine report, *The Future of Nursing (2011)*, recommends federal and state action to update regulations to ensure that all advanced practice nurses practice to the full extent of their education and training. The Rand Report for the Massachusetts Division of Health Care Finance and Policy has recommended independent practice for advanced practice nurses.⁸⁹ However, the Massachusetts Psychiatric Society (MPS) through its Task Force representative, strongly opposed the expansion of the scope of services and the removal of physician supervision of advanced practice nurses. MPS does not endorse this recommendation in its entirety. MPS believes expanding the scope of practice for independent practice for psychiatric clinical nurse specialists may not effectively contain costs in an underfunded behavioral health system or necessarily be an effective solution to expanding access to psychiatric medications.

Many Task Force members endorse a review of the scope of practice rules, but do not recommend whether certain professionals' scope of practice should be expanded.

Implementation Action Steps: A thoughtful and thorough review of scope of practice rules for certain professions should be conducted by DPH and the Office of Consumer Affairs and Business Regulation to determine whether expanding the scope of practice rules for advanced practice nurses is a reasonable way to address workforce shortage and the expansion of behavioral health services. Such review should examine the training and ongoing certification requirements of these professionals to determine whether the skills and knowledge expected to be gained from such training and certification would allow for the continued safe and effective delivery of care. If such training and ongoing certification is not sufficient, the review should identify what additional requirements would be necessary and whether those additional requirements would lead to a more advanced degree. In particular, the review should examine the

⁸⁹ Eiber, Hussey, Ridgely and McGlynn, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009.

states that have passed independent practice laws for psychiatric clinical nurse specialists and identify any consequences (either intended or unintended) as a result of the legislation.

In addition, payers should provide reimbursement for all services that can be conducted under Massachusetts's statutory scopes of practice including non-discriminatory use of all CMS approved CPT codes by psychiatric physician and advanced practice nurses.

24. Licensing boards or agencies for the medical and behavioral health professions should review licensure statutes and regulations to ensure that training requirements are consistent with the skills needed to practice effectively in integrated settings.

Rationale: The Task Force members believe that behavioral health care can be delivered by many different types of providers, including individuals that may not be currently licensed under state statute (e.g., peer support). Task Force members felt it important to identify and remove barriers that prevent professionals such as recovery coaches and peers from participating in care provided to individuals and families under new payment reform models. In addition, some licensure laws and/or regulations do not allow for training sites used towards licensure to be located in sites where integrated services can now be delivered such as school health clinics.

Implementation Action Steps: DMH, DPH and the Office of Consumer Affairs and Business Regulation should be encouraged to identify training and/or certification programs that ensure that a minimum standard of training is met by those providing services not currently under regulatory authority.

25. Actively foster and fund leadership development among all segments of the workforce, including peers.

Rationale: Leaders are needed in all levels of the field from practice administration to peer and family support services to support the transformation of the behavioral health system to be one that is less siloed and more coordinated with the medical system. For example, leadership is a key factor to the adoption of evidence-based and emerging promising practices in the mental health and addiction treatment systems.⁹⁰

Implementation Action Steps: Leadership qualities that are necessary to assist in achieving higher quality of care and lower costs through transformation of the behavioral health system of care must first be identified. Such qualities should include

⁹⁰ National Association of State Mental Health Program Directors Research Institute, Inc. "Results of a survey of state directors of adult and child mental health services on implementation of evidence-based practices." Alexandria, VA 2005. http://www.nri-inc.org/reports_pubs/2005/EBPLillyFullReport2005.pdf

the skills needed for organizational transformation as well as community transformation. After leadership qualities are identified, programs that support leadership training in Massachusetts should be funded to train behavioral health providers. Leaders invited to participate in training programs should be chosen with the intent to pull a diverse group of leaders together for learning.

One important forum in which leadership will be critical is the leadership of Accountable Care Organizations (referred to as integrated risk bearing provider organizations, throughout this report). Chapter 224 requires that these organizations include a consumer representative in their governing structure. While many Task Force members believe that persons with lived experience are often left out of governing bodies, one Task Force member expressed the concern that too many individuals within a governing body will make an ineffective governing organization and that integrated risk-bearing provider organizations should have the flexibility to determine whether more than one individual with lived experience be represented on a governing body. Therefore, the Task Force recommends that integrated risk-bearing provider organizations consider appointing more than one person with lived experience from the population served including a representative of at least one person from each of the following groups: families whose children receive both primary and behavioral health care, transition age youth who receive both primary and behavioral health care, and adults who receive both primary and behavioral health care.

26. Organizations that accept financial risk for provision of services, including integrated risk bearing provider organizations, should automatically be given designated status from a managed care entity to take on responsibility for the credentialing of its providers panel.

Rationale: Credentialing is agreed to be a patient safety protection that is in place to ensure that providers are qualified to perform within the scope of their practice, to identify medical malpractice instances, and to ensure providers are appropriately licensed. There is a belief in the Task Force that managed care organizations sometimes use the credentialing process to limit the growth of provider panels, including limiting access of smaller behavioral health practices to their provider networks. Task Force members believe that, to the extent that there is not a public credentialing body independent of managed care organizations, delegating providers with the responsibility to credential may promote efficiency, as most provider organizations already conduct credentialing activities prior to hiring a new provider. The current system of credentialing can be slow, often requiring many months before a provider can be credentialed which renders them unable to provide care during that time. Under this recommendation, provider organizations also would have greater flexibility to

target the needs of their populations and expand their networks of participating behavioral health providers and promote integration, both in terms of numbers and use of emerging providers such as peer specialists, enabling the organization to include providers best suited for the needs of the individual. In addition, Task Force members believe that credentialing may be completed more quickly at a provider organization which feels a greater urgency to add new, qualified providers. However, there is still a need to have a credentialing process for some behavioral health providers in certain individual or group practices that contract independently.

The Task Force recognizes that health plans are required under Massachusetts law to achieve accreditation from the National Committee on Quality Assurance (NCQA) and the Board of Registration in Medicine (BORM). NCQA requires credentialing of providers and applicable oversight by plans. While plans may continue to be accredited if a subset of its providers are delegated entities, the plans must retain the ultimate responsibility for the credentialing and ensure that delegated entities meet all credentialing standards.

For the past several months, health plans, hospitals and the Massachusetts DOI have been meeting on a regular basis to develop uniform credentialing criteria that will reduce administrative burden on providers. Work must also be done with these groups to identify and eliminate barriers to timely credentialing.

Implementation: As a first step in implementing this recommendation, the DOI should be charged with determining the impact of this recommendation on plans' ability to receive NCQA accreditation to ensure that delegation does not jeopardize that accreditation. In concert with current efforts to simplify and centralize the credentialing process, DOI should work with its current working group to determine the amount of delegation, if any, that occurs today, consider the criteria for delegated entities and whether and how that differs from the credentialing requirements for plans themselves. Where delegation does occur today, the DOI, plans and potential delegated entities should review the performance of provider organizations that have accepted this responsibility and try to ascertain the organization's overall quality and diversity of providers and overall performance, including a combination of health outcomes and financial measures. As additional organizations become delegated entities, the DOI should continue to monitor the impact of this recommendation in increasing integration of behavioral health care within organizations that accept risk, including progress in hiring new types of providers, the quality of providers within the organization, and ability to meet health outcome and financial performance standards. Ultimately, with public input, the DOI should develop uniform credentialing standards that do not restrict behavioral health providers.

F. Other Recommendations

In addition to the recommendations above, the Task Force makes the following three recommendations for the consideration of the Legislature and the Health Policy Commission.

27. The Health Policy Commission should be charged with developing further recommendations, clarifications and proposals to assist the Legislature and the Health Policy Commission to operationalize and subsequently evaluate the integration and reimbursement of behavioral health care in a new climate of integrated care.

Rationale: With a continued focus on behavioral health integration across the state and throughout different agencies, the Task Force believes that it is important to align the different stakeholders and workgroups into one common body that reports to the Health Policy Commission. Some of the recommendations of the Task Force involve actions by state agencies (e.g., Division of Insurance) and stakeholders (e.g., commercial health insurers) who did not participate in Task Force discussions but who are actively involved in workgroups and activities of the Health Policy Commission. This will require the participation of all relevant state agency and external stakeholders to allow for a coordinated and sustained approach to ensure that the Task Force recommendations are implemented.

Implementation: A subcommittee to the Health Policy Commission should be developed that incorporates representatives of existing behavioral health initiatives, including the MA PCMHI, MassHealth PCPR, and the CBH Advisory Council. In addition, persons with lived experience of mental health and addiction issues, family and transition-age youth should be represented on this new subcommittee. Continued participation of interested Behavioral Health Integration Task Force members is recommended.

The new subcommittee should be responsible for monitoring the implementation and evaluation of the recommendations made by the Task Force. It should also be tasked with evaluating the success of integration under alternative payment methodologies and integrated model types and be given the authority to make additional recommendations to improve the integration of care in Massachusetts.

28. Management of payment for behavioral health services should promote coordinated and integrated care that prevents fragmentation and redundancy. There should be further study of whether a Behavioral Health Carve-Out model continues to be appropriate and is able to deliver integrated care.

Rationale: Given the renewed focus of integrated care, the role of carve-outs going forward should be examined and discussed. This Task Force was unable to have a detailed discussion of the topic.

Implementation: The Task Force recommends that a study about behavioral health carve-outs be conducted by the Health Policy Commission under the direction of the subcommittee called for in Recommendation #27.

29. Medically necessary behavioral health services, including collateral contacts, should be reimbursable outside of the medical/behavioral health care setting (e.g., in educational, child welfare, juvenile justice, and community and home settings) as equivalent services delivered in medical/behavioral health care settings and should be included in publicly and commercially available health care benefits.

Rationale: Currently in Massachusetts, there are nearly 1 million students enrolled in public elementary and secondary schools; of these, over 160,000 receive special education services, often for emotional or behavioral disabilities. Moreover, there are nearly 10,000 youth in foster care in Massachusetts and an estimated 6,000 children are court-involved. These youth have much higher rates of behavioral health disorders than the general population of youth; yet they often experience many barriers to the receipt of quality behavioral health services. Behavioral health services provided in these settings have the potential to improve learning, family reunification, and exit from juvenile delinquency. The cost of providing behavioral health services in these settings does not differ from outpatient settings, and in fact, may be less expensive in the absence of high medical care facility fees. Accordingly, Task Force members support equal professional payment rates for medically necessary behavioral health services delivered in alternative settings such as those delineated above.

Implementation Action Steps: The Legislature should require MassHealth and commercial insurers to pay for medically necessary behavioral health services by a particular provider, regardless of the setting for the services.

VII. Conclusion

The recommendations provided above answer the specific questions asked by the Legislature within Section 275 and provide additional recommendations aimed at the successful integration of primary care and behavioral health care with the goal of enhancing access to behavioral health within primary care to improve health care outcomes and contain health care cost growth. The Task Force believes that successful integration requires the implementation of strategies to appropriately reimburse for provision of behavioral health services within primary care and elsewhere within the health care system, to thoughtfully address privacy to balance individual and provider concerns, to appropriately develop the workforce to provide integrated care, including through expansion of types of providers, and to train all types and levels of providers on models of integration and best practices. We look forward to participating in continued discussion of these important issues.

VIII. Resources

Integrated Behavioral Health and Primary Care Resources

1. **Substance Abuse and Mental Health Services Agency, Center for Integrated Health Solutions**
<http://www.integration.samhsa.gov/>
2. **National Council for Behavioral Health**
<http://www.thenationalcouncil.org/cs/home>
3. **Health Reform and Behavioral Health Services in Massachusetts: Prospects for Enhancing Integration of Care**
<http://masshealthpolicyforum.brandeis.edu/forums/Documents/health-reform-and-behavioral-health-services-in-ma.pdf>
4. **Integrated Care Resource Center**
<http://www.integratedcareresourcecenter.com/>

Alternative Payment Models

1. **Center for Healthcare Quality and Payment Reform**
<http://www.chqpr.org/>
2. **Catalyst for Payment Reform**
<http://www.catalyzepaymentreform.org/>

IX. Appendix A. Behavioral Health Task Force Members

Department of Mental Health	Marcia Fowler, Commissioner
Massachusetts Psychiatric Society	Janet Osterman, MD
Massachusetts Psychological Association	Elena J. Eisman, EdD, ABPP
National Association of Social Workers - MA Chapter	Bruce A. Maloof, PhD, LICSW, BCD, LADC
Massachusetts Mental Health Counselors Association	David McAllister, LMHC
Nurses United for Responsible Services	Virginia Tay, PhD, RN, CS
Massachusetts Association of Registered Nurses	Karin Narkun, RN-BC, BSN
Massachusetts Association of Behavioral Health Systems	David Matteodo
Association for Behavioral Healthcare	Vicker DiGravio
Mental Health Legal Advisors Committee	Susan Fendell
National Alliance on Mental Illness of MA	Laurie Martinelli
Children's Mental Health Campaign	Mary McGeown
Home Care Alliance of Massachusetts	Donna Vaskelis
National Empowerment Center	Daniel Fisher, MD, PhD
Massachusetts Organization for Addiction Recovery	Maryanne Frangules
Recovery Homes Collaborative	John McGahan, LADAC I, CAS
Massachusetts Hospital Association	Heather J. Walter, MD, MPH
School Nurse	Mary Ann Gapinski, MSN, RN, NCSN
Provider with Experience Serving a Difficult to Reach Population	Monica Bharel, M.D., M.P.H.

Behavioral Health Integration Task Force Participants

Lahey Health Behavioral Services	Mona Bastide, LICSW
DPH Bureau of Substance Abuse Services	Hilary Jacobs, LICSW, LADC I

X. Appendix B. Meeting Topics and Materials Presented to Task Force Meetings or Shared By Task Force Members

Date	Meeting Topic
December 18, 2012	<ul style="list-style-type: none"> • Welcome and introductions • Discussion of scope, identification of key issues (and definitions) • Presentation of project plan
January 14, 2013	<ul style="list-style-type: none"> • Behavioral health integration activities in Massachusetts
February 26, 2013	<ul style="list-style-type: none"> • Clinical models for behavioral health integration
April 8, 2013	<ul style="list-style-type: none"> • Workforce and Reimbursement
April 30, 2013	<ul style="list-style-type: none"> • Communication and Privacy
May 7, 2013	<ul style="list-style-type: none"> • Children’s Behavioral Health Advisory Council • Physician Work Group Recommendations • Persons with Lived Experience
May 21, 2013	<ul style="list-style-type: none"> • Review of recommendations
June 4, 2013	<ul style="list-style-type: none"> • Review of draft report
June 18, 2013	<ul style="list-style-type: none"> • Vote on final report

List of Presentations and Materials Given to the Behavioral Health Integration Task Force

Presentations and materials will be made available on CD-ROM to the Legislature

Background Materials

Behavioral Health Integration Task Force Briefing Book

Prepared by Bailit Health Purchasing.

General HIPAA and Privacy Laws

Prepared by DMH Legal Office.

Presentations

Behavioral Health Integration: Kick Off Meeting

Presentation by Bailit Health Purchasing

Behavioral Health Integration: Meeting 2

Presentation by Bailit Health Purchasing

Behavioral Health in Primary Care Payment Reform and Health Homes

Presentation by Julian Harris, MD, Medicaid Director

Behavioral Health Integration

Presentation by Daniel Gallery, PsyD

Chief of Behavioral Health, Medford - Harvard Vanguard; and

Thad Schilling, MD

Medical Director, Patient-Centered Medical Home

Associate Chief of Internal Medicine, Medford - Harvard Vanguard

Massachusetts Association of Health Plans: Presentation for Behavioral Health Integration Task Force

Presentation by Sarah Gordon Chiaramida, Massachusetts Association of Health Plans

Behavioral Health Integration: Progress and Challenges

Presentation by Alexander Blount, Center for Integrated Primary Care, University of Massachusetts Medical School

MA Child Health Quality Coalition's Task Force on Communication and Confidentiality

Presentation by Frances O'Hare, MD

White Papers

Consumer Control of Mental Health Information

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Eradicating Stigma in Healthcare Systems

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Caseloads, Time, and Quality of Care

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Importance of Choice of Provider and Treatment

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Reports & Recommendations

Children's Behavioral Health Advisory Council Recommendations to the Behavioral Health Integration Task Force

Children's Behavioral Health Advisory Council, May 2013.

Physician Work Group Recommendations to the Behavioral Health Integration Task Force

Physician Work Group, May 2013.

An Integration Model for Medicaid-Financed Behavioral Health Services

Recommendations to Joshua M. Sharfstein M.D., Secretary of Maryland Department of Health and Mental Hygiene, 10/1/12.

Shared Principles on Integration and Dual Eligible Demonstration, December 19, 2012

Prepared by Disability Advocates Advancing Our Healthcare Rights (DAAHR) and

The Association for Behavioral Healthcare (ABH).

A Guide to Building Collaborative Mental Health Care Partnerships In Pediatric Primary Care

American Academy of Child & Adolescent Psychiatry, Committee on Collaboration with Medical Professionals, May 2010.

Best Principles for Integration of Child Psychiatry into the Pediatric Health Home

American Academy of Child and Adolescent Psychiatry, June 2012.

Chronic conditions and comorbid psychological disorders

Milliman Research Report, July 2008.

Recommendation from the Community Preventive Services Task Force for Use of Collaborative Care for the Management of Depressive Disorders

(Am J Prev Med 2012;42(5):521–524) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine.

Behavioral Health Homes For People With Mental Health & Substance Use Conditions: The Core Clinical Features

SAMHSA-HRSA Center for Integrated Health Solutions, May 2012.

The Annual Cost of Brain Disease in 2012

PricewaterhouseCoopers LLP, Summer 2012.

Health Reform In Oregon: An Opera Grand/Bufa? (in Four Acts)

David Pollack, MD

Professor For Public Policy

Oregon Health & Science University

With supporting materials from OHA

Behavioral Health Integration RFI and Public Forums Summary/Themes

Prepared by DMH, May 1, 2013.

Dan Fisher's Notes from March 26, 2013 Behavioral Health Integration Public Forum

Physician Supervision of Prescriptive Practice for Psychiatric Clinical Nurse Specialists

Prepared by Virginia Tay.

Articles/Journal Publications

How I Helped Create a Flawed Mental Health System That's Failed Millions - And My Son

Health Affairs, 31, no.9 (2012):2138-2142.

Collaborative Depression Care Models From Development to Dissemination

Am J Prev Med 2012;42(5):550–552.

Mental Health Treatment Should Focus On Recovery

The Hartford Courant, January 25, 2013.

Sharing Psychiatric Records Helps Care

New York Times, January 7, 2013.

Clinics bring together doctors and psychiatrists to cure physical, mental health ailments

Washington Post, February 18, 2013.

Time to Advance the Confidentiality Conversation

March/April 2013, vol. 33, no. 2, Behavioral Healthcare.

Long-term Antipsychotic Treatment and Brain Volumes

Arch Gen Psychiatry. Author manuscript; available in PMC 2012 October 19.

Published in final edited form as: Arch Gen Psychiatry. 2011 February; 68(2): 128–137.

Poverty and Mental Health Practice: Within and Beyond the 50-Minute Hour

Journal of Clinical Psychology: In Session, Vol. 69(2), 182-190(2013).

Psychiatrists Not Immune to Mental Health Bias

Medscape. May 21, 2013.

Earning a Teenager's Trust

Medscape. Apr 01, 2013.

Promoting Recovery

(In: T Stickley and T Basset (Eds.) Learning About Mental Health Practice. Chichester, England: John Wiley and Sons.2008.) Chapter written by Daniel B. Fisher, M.D., PhD.

Letters

MassHealth Programs Compliance with Mental Health Parity Laws

March 2013 letter to Julian Harris, MD, Medicaid Director, from healthcare provider trade associations and advocacy organizations.

Joint Provider Comments on Implementing Chapter 224 of the Acts of 2012 provisions related to Mental Health Parity (Section 23 & 254)

September 2012 letter to Kevin Beagan, Division of Insurance, from healthcare provider trade associations.

MassHealth Compliance with MHPAEA

April 2012 letter to Julian Harris, MD, Medicaid Director, from the Center for Public Representation.

Other Documents

Statement by David Kupfer, MD, Chair of DSM-5 Task Force Discusses Future of Mental Health Research

May 3, 2013 Release No. 13-33.



**MA Child Health Quality Coalition's Task Force on
Communication and Confidentiality
Presentation to Behavioral Health Integration Task Force**

4-16-13

Presented by

Frances O'Hare, MD,

Pediatrics, Transition Coordinator,

HMS Center for Primary Care Academic Innovation Collaborative Transformation Grant,

Martha Eliot Health Center, Boston Children's Hospital

The MA Child Health Quality Coalition is a public-private partnership with broad-based, cross-stakeholder representation championing and advocating for child health care quality and measurement statewide, funded through a CMS CHIPRA Quality Demonstration Grant, with Massachusetts Health Quality Partners serving as its operational home.

Handouts:

Background information on the MA Child Health Quality Coalition and its Task Forces on Care Coordination and Communication and Confidentiality

Status report from the MA Child Health Quality Coalition's Communication and Confidentiality Task Force

Membership list for the MA Child Health Quality Coalition's Communication and Confidentiality Task Force

Outline of topics proposed for inclusion in a Communication and Confidentiality Resource Guide being developed by the MA Child Health Quality Coalition's Communication and Confidentiality Task Force

Suggestions to the Child Behavioral Health's Advisory Council to consider for inclusion in the Council's recommendations to Behavioral Health Integration Task Force on Confidentiality/Privacy Issues

MA Child Health Quality Coalition

Vision Statement

To achieve and sustain transformational gains in child health care and outcomes, across the care continuum, for all children in Massachusetts.

Mission Statement

The mission of the Massachusetts Child Health Quality Coalition is to champion and advocate for child health care quality and measurement, facilitate a shared understanding of pediatric health care quality priorities across a broad-based set of stakeholders in Massachusetts, create a platform for formulating system-wide goals and objectives, and implement activities to support those goals and objectives.

Key Coalition Objectives

Promote improvements in health care outcomes for children in Massachusetts by developing consensus around priorities for action and supporting the implementation of activities in those priority areas;

Advocate for inclusion of child health issues in broader statewide activities;

Provide direction on the development of new measures to evaluate and track progress related to children's health care;

Create synergies among existing child health measurement and improvement activities to increase impact; and

Develop and implement plans to ensure the Coalition's long term sustainability.

Care Coordination Context:

Improving care coordination for children has been demonstrated to improve quality of care while controlling costs. Effective care coordination can also lead to improved care integration for children with behavioral health care needs. Coalition members have emphasized the gaps in the coordination of care for children with behavioral health needs, and the benefits that can accrue from more integrated care.

The Coalition developed a Care Coordination Key Elements Task Force to define and support the implementation of a set of foundational elements of high-performing pediatric care coordination. The Coalition also developed a Communication and Confidentiality Task Force to support effective communication between and among those who make up the child's "coordination network," while addressing issues of confidentiality. The first Task Force's work is resulting in a set of key elements of care coordination and associated measures, and the second Task Force's work is resulting in a resource guide. The Coalition's cross-stakeholder representation offers an excellent forum for developing consensus around useful, feasible strategies to support the effectiveness of care coordination.

MA Child Health Quality Coalition

Task Force #2: Communication and Confidentiality

Task Force Objective: Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.

Current Status

The Communication and Confidentiality Task Force has identified a number of challenges to communication, including:

- difficulty in attaining and maintaining trusting relationships between parents/youth and providers
- a misunderstanding of the importance of information sharing to facilitate the delivery of coordinated care
- a lack of understanding of rules governing information sharing (which becomes all the more challenging when schools are involved)
- a lack of structures and methods to support information sharing among providers, families/youth, schools, and other members of the child's coordination network

Additionally, the Task Force wanted its work to also address the issues of confidentiality that are important to consider in any communication facilitation effort, and to highlight those confidentiality issues that are of particular concern when behavioral health issues are involved.

The Task Force noted that tools do exist to address these communication challenges, but that many of these are not well known or easily discoverable to most families, providers and community-based programs. Thus, the Task Force determined that collecting and compiling these tips, tools and resources in one place, in a format that can be easily used by the various members of the child's coordination network, would be of value, and it therefore decided to work on creating a Resource Guide.

The group is currently working on refining the concepts and components to be included in this Resource Guide, and determining what format and content might make the Guide most useful to potential users. The target date for completion of the Guide is December 2013.

Task Force #2: Communication and Confidentiality Members

Name	Title	Organization
Chair		
Kathy Hassey	Director, School Health Institute	Northeastern University School of Nursing
Task Force Members		
Craig Bennett	Attorney/Family Law	Boston Children’s Hospital
Elena Eisman	Executive Director/Director of Professional Affairs	Massachusetts Psychological Association
Lloyd Fisher, MD	Site Chief/ Assistant Medical Director for Informatics	May Street Pediatrics/Reliant Medical Group
Heather Frohock	Lead Youth Advocate	YouthMOVE Massachusetts and PPAL
Linda Grant, MD	Provider, Adolescent Pediatrics Medical Services Director/Special Education	Boston Medical Center, Boston Public Schools
Cathy Hickey	Information Specialist	Mass Family Voices/ Family to Family Health Information Center at Federation for Children with Special Needs
Lisa Lambert	Executive Director	Parent/Professional Advocacy League
Frances O’Hare, MD (Kitty)	Pediatrics, Transition Coordinator, HMS Center for Primary Care Academic Innovation Collaborative Transformation grant	Martha Eliot Health Center Boston Children’s Hospital
Beth Pond	Family Integration Specialist	Parent/Professional Advocacy League
Jennifer Reen	School Psychologist/Clinical Counselor	Lincoln-Sudbury Regional High School
Staff Lead		
Valerie Konar	Project Manager, CHIPRA Quality Demonstration Grant	University of Massachusetts Medical School

MA Child Health Quality Coalition

Communication and Confidentiality Task Force

Suggestions for the Behavioral Health Integration Task Force Recommendations
on Confidentiality/Privacy Issues

(3-18-13)

The MA Child Health Quality Coalition has an active **Communication and Confidentiality Task Force** created to support its work promoting improved care coordination for children in Massachusetts, including addressing special issues for children with behavioral health needs.

***Task Force Objective:** Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.*

This Task Force has been identifying issues impacting communications and confidentiality across the Coalition's different stakeholder groups and identifying resources that can help in addressing those issues. Based on the task force work to date, the following recommendations for confidentiality and privacy considerations should be considered:

(1) Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

(2) Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages.

Provide guidance on the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.).

Strategies that encourage information sharing (e.g. "opt out") still need safe guards that ensure informed consent.

Special issues of confidentiality must be considered for adolescents

Peer networks offer important opportunities to support youth in understanding privacy protections and promote **strategic sharing**

(3) Sharing behavioral health information with families/youth can improve accuracy and patient safety.

(4) Look at privacy as a whole, not just within electronic health records.

Behavioral Health Integration
Request for Information and Public Forums

Summary

May 1, 2013

Section 275 of the Health Care Cost Containment Law established a Behavioral Health Integration Task Force chaired by the Commissioner of the Department of Mental Health (DMH). To help inform Task Force members, DMH published, in February, 2013, a Request for Information (RFI) and, in March, held two public forums; one in Boston and one in Holyoke. The RFI and forums focused on questions posed in Section 275, including the integration of behavioral health and primary care.

The following is a summary of themes that emerged from the 65 RFI responses (peers, providers, hospitals, trade associations, health plans, licensed independent practitioners, advocacy organizations) and more than 100 participants who attended one of the public forums. This summary is a compilation of the suggestions and comments of the RFI respondents and represents the Department's best attempt to summarize these comments. It is not a complete list of all comments submitted or expressed at the public forums, nor does it constitute or imply endorsement or acceptance of any such suggestions and comments by DMH or the Task Force.

Behavioral Health Integration RFI/Public Forums Themes

1. Clinical Models

- a. Significant support for integration through a variety of clinical models including full integration, co-location within primary care, reverse co-location of primary care within behavioral health clinics and coordination. There was also some support for developing full integrated health care clinics within school based clinics and integration within the acute mental health setting.
- b. Many respondents specifically referenced the National Council's Four Quadrant model as a reasonable approach to identifying which consumers could potentially receive the most appropriate level of care within varied integrated care settings.
- c. With respect to full integration, many respondents indicated that they believe that individuals whose healthcare needs match Quadrant I (low to moderate behavioral health and low to moderate physical health) may be best matched to benefit from brief behavioral health intervention and care coordination within primary care. This type of integration supports individuals in accessing and adhering to behavioral health treatment; it does not replace the outpatient behavioral health provider.
- d. Many respondents indicated support for across-the-board behavioral health screening for conditions for which there is a validated and standardized screening tool (e.g. PHQ-9, SBIRT, CAGE, etc.). In addition, many respondents indicated brief intervention, motivational interviewing, behavioral activation, stress management and referral to treatment should be used to follow-up to screening.
- e. Maximizing use of integrated care planning.
- f. Inherent to all models, concerns were expressed about the need to assure adequately trained behavioral health clinicians are available to meet the needs of individuals who screen positive for a behavioral health service. If there isn't a supply of trained personnel within the Primary Care setting and outside, the responsibility for care will be unfairly shifted from the PCP to behavioral units without resources to match.
- g. With the emergence of office based treatment for opioid addiction and screening for early detection of problematic substance use, behavioral health specialists who are experienced and certified in addiction treatment based in primary care settings may reach a broader population who may not otherwise have sought treatment.

2. Reimbursement

- a. Almost unanimously, concern was expressed about need to ensure that behavioral health rates are adequate to support the full range of services whether or not part of an alternative payment model (capitation or bundle) or fee for service.
- b. Care coordination- many different layers and staff have been identified to deliver care coordination without clear guidelines for prioritization, volume and rate of reimbursement.

- c. Clear recommendations were expressed to ensure that screenings and appropriate follow-up meet the definition of a covered service. In addition, service planning should be a covered service.
- d. Reimbursement for psychiatry consultation to primary care providers was widely supported, particularly for child/adolescent and areas that have low resource availability.
- e. Many respondents expressed deep concern that performance incentives in risk adjusted models that use behavioral health screening as a measure need to be monitored for behavioral health follow up rate not just screening and referral.
- f. Some respondents specifically indicated that behavioral health providers who practice in integrated systems or a part of a coordinated system should be included in any shared savings model.
- g. Many respondents expressed need to have restrictions that prohibit billing for same day primary care and behavioral health and that prohibit billing for behavioral health without a mental health clinic license eliminated as these are inconsistent with integration.
- h. As Massachusetts moves toward a matrix of payers with very different payment structures, the administrative rules for meeting the varied network requirements is creating increased administrative burdens not simplification.
- i. Independent practice behavioral health clinicians are looking for strategies to coordinate but not integrate and are concerned about preserving adequate reimbursement streams in rate capitation models where they may be out of network.
- j. In reimbursement models for behavioral health that remain fee for service or are included within an alternative payment model (capitation or bundles), many respondents expressed need to create a reimbursement rate category for peer/family partner services as well as other health outreach worker and navigator roles.
- k. Several respondents recommended examination and/or elimination of prior authorization requirements for standard behavioral health (akin to referral from primary care for other medical specialty services) to support a more natural work flow between primary care and behavioral health.
- l. There was a desire for clear policies and mechanisms for reimbursement for non-face-to-face aspects of care (e.g., “collateral contacts,” telephone interventions, coordination between providers and between providers and community supports.)
- m. Reimbursement should be available for longer visits.

3. Workforce

- a. There was almost unanimous support for expanding the ‘trained’ peer, family partner, and health outreach and navigator workforce. In some responses ‘trained’ was directly associated with certification while in others it was associated with lived experience or training in whole health resiliency models.

- b. Access to and supply of trained licensed behavioral health professionals of all specialties was frequently discussed as a challenge to meeting the full demand that increased screening may produce.
- c. There were a number of specific recommendations about the value of training both medical and mental health specialists in the delivery of screening and treatment for problematic substance use and addiction. Encourage certification where possible. Offer substance use disorder CMEs.
- d. Many respondents expressed concern that closed networks may force patients who may have strong therapeutic alliances to choose between their providers and health coverage requirements.
- e. Access to psychiatry in some areas and for child/adolescent groups, in particular will challenge the health care system to develop creative solutions (e.g. MCPAP) to meet demand.
- f. Many respondents expressed need to ensure that networks had robust referral relationships to psychological and neuropsychological resources to ensure timely access to specialized assessments and for follow-up to universal screening. Several respondents noted concerns about the heavy administrative authorization requirements to seek reimbursement for such specialty referrals.

4. Freedom of Choice

- a. Many respondents who self identified as engaged in behavioral health treatment expressed concern that they will lose trusted providers in the evolving health care system.
- b. Many behavioral health clinicians expressed concern that either by network structure or loss of revenue, they will be forced out of practice or moved into a private pay market share.
- c. Some respondents expressed concerns that integration would mean an inability for the patient to choose their behavioral health provider, or that seeking care in an integrated environment would prevent them from seeking behavioral health care outside of the integrated environment.

5. Privacy

- a. There was a full range of comments regarding confidentiality/privacy laws and electronic health records access. Comments ranged from absolutely no access to behavioral health records to limited sharing with consent to full sharing with and not explicitly with consent to 'opt in' and 'opt out' options.
- b. In health care environments where there is shared electronic health records access, there were many recommendations for requiring technological solutions, like firewalls and password access to behavioral health records along with clear written consent protocols.
- c. History of and risk for continued discrimination on the basis of behavioral health status were most frequently cited as the reasons for concerns about sharing behavioral records.
- d. For respondents who were commenting from the perspective of family and child/adolescent care perspectives, additional concern was expressed regarding health care information about parents that may be present in a

child health record posing exposure risk in custody hearings. In addition, there was concern about adolescent and teen issues (e.g., substance use, pregnancy) being exposed to the parents without permission.

6. Regulatory

- a. Several respondents requested review and elimination of clinic license regulations that directly conflict or are contradictory to the integration effort (e.g. requirement for segregated waiting room spaces).
- b. Some respondents expressed desire for a greater degree of alignment of state oversight bodies, specifically DPH, DMH and MassHealth. As varied healthcare reform initiatives are being tested through demonstration projects, multiple reporting requirements may create need for redundant systems.
- c. There needs to be consumer education, transparency, and strong enforcement of state and federal parity laws. Integrated models of care will require additional standards to ensure parity compliance. Some respondents expressed concerns with compliance by behavioral health “carve-outs”.

7. Performance Measurement

- a. Many respondents recommended alignment of performance measures across the varied demonstration projects (e.g. PCMH, Duals Demonstration, Health Home).
- b. One respondent importantly noted that there is a difference in measuring the extent of integration and measuring the quality of services in integrated settings.
- c. Recommendations for performance measures in integrated settings included:
 - i. # of individuals who received behavioral health screening in the primary care setting and rate of follow through in treatment
 - ii. Length of time on referral waitlists
 - iii. Medication reconciliation at each transition of care
 - iv. Satisfaction with services
 - v. HEDIS 2012
 - vi. NQF Behavioral Health Integration
 - vii. ED use for behavioral health / mental health needs

8. Care Coordination

- a. Close partnerships between primary care providers (and their care management staff) and behavioral health providers is necessary to ensure ready access to services, coordination and continuity.
- b. Disease registries, tracking registries or use of an informatics system were suggested as ways to help enhance care coordination across multiple settings and reduce duplication of services. These systems could also be used to track symptom and functional improvement.

9. Education and training

- a. Importance of mandatory education/training of PCPs in relation to treating physical conditions of those with BH needs can't be overstated, but needs to be targeted.
- b. Should educate about Metabolic Syndrome – b/c greater impact on overall physical health (MAMH); particularly true for patients with schizophrenia.
- c. Training on screening and use of assessment tools (for PCPs).
- d. Training for BH providers to manage some medical issues.
- e. Training for PCPs should include people with lived experience.
- f. Training on person-centered care.
- g. Training in addiction medicine.
- h. Destigmatizing mental health.
- i. Suggestion that PCP settings provide focus groups/sessions on impact of drug/alcohol/tobacco; sponsoring recovery support activities; mindfulness groups to reduce stress; etc.
- j. Educate consumers about purpose and benefits of integrated care.

**Children's Behavioral Health Advisory Council
Recommendations to the Behavioral Health Integration Task Force**

The Children's Behavioral Health Advisory Council is pleased to provide the Behavioral Health Integration Task Force with advice and recommendations on the issues identified in Section 275 of Chapter 224 as they affect behavioral health care for children.

The Council was established by *Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental Health* as part of a comprehensive set of reforms in the children's behavioral health system. The Council is a unique public-private partnership representing child-serving agencies, parents, and professionals with knowledge and with expertise in the field of children's behavioral health. Council activities have ranged from viewing initial data on service utilization and penetration, including In-home Therapy, Intensive Care Coordination and Family Support and Training, to a detailed and thorough review of commercial insurance practices; from examining the challenges of workforce development to the research and development of culturally-informed best and promising practices, and the reduction and elimination of racial and ethnic disparities. We take a broad view of child health as encompassing healthy development over time, not just the amelioration of problems. Although much of our work has focused on reforms in the public children's behavioral health system, our purview encompasses the entire children's behavioral health system, both public and private payers.

We welcome the opportunity to assist the Behavioral Health Integration Task Force (BHITF) in completing its charge as outlined in *Section 275 of Chapter 224: An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*. We view Chapter 224 as the next critical phase in the ongoing improvement in the children's behavioral healthcare system. Over the past few years, significant effort and investment have been made to improve the MassHealth children's behavioral health system, which serves approximately one-third of the children in the Commonwealth. Some of that investment has extended into the privately insured healthcare system, e.g. the Massachusetts Child Psychiatry Access Program.

Our recommendations are informed by our work together over the past five years as a Council. In addition, we invited leaders from MassHealth's Patient-Centered Medical Home Initiative, the Child Health Quality Coalition, and Boston Children's Hospital to share their expertise with us. Some Council members also attended the Task Force's early meetings in order to learn from its expert guests. Several Council members have shared their professional organizations' (e.g., AACAP, AAP) white papers on primary and behavioral health integration. We are excited to see an emerging consensus about the key principles and strategies for improving healthcare quality and cost through primary and behavioral health care integration. We hope our advice helps to move the conversation from conceptual to operational.

CHILDREN AND HEALTHCARE REFORM

- Approximately one in five children and adolescents experiences the signs and symptoms of a diagnosable mental health disorder during the course of a year. Among children ages 9 to 17, 11 percent experience “significant impairment” and 5 percent experience “extreme functional impairment.”⁹¹
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.⁹²
- About 36% of youth with any lifetime mental health disorder receive services, and only half of these youth who were severely impaired by their condition received professional mental health treatment. The majority (68%) of the children who did receive services had fewer than six visits with a provider over their lifetime.⁹³

It would be easy, but a mistake, to overlook the needs of children in the context of the healthcare reform efforts required by Chapter 224. Children are not “cost drivers” when compared to some groups of adults, e.g. adults eligible for both Medicaid and Medicare. However, without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults.⁹⁴ Moreover, the Adverse Childhood Events literature (discussed below in Section V) underscores the impact of the consequences of adverse childhood events on adult physical and behavioral health morbidity, mortality and costs.⁹⁵ There is clear and expanding scientific evidence that toxic stress, associated with adverse child events, can permanently alter brain maturation broadly and particularly in the prefrontal cortex, hippocampus and amygdala, as well as the nerve interconnections between them. These brain changes may be permanent and may not change easily, once established, underscoring the importance of prevention and early intervention.⁹⁶

GUIDING PRINCIPLES

⁹¹ Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999

⁹² NIMH, Mental Illness Exact Heavy Toll, Beginning in Youth, June 2005.

⁹³ NIMH. Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services, January 04, 2011

⁹⁴ Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

⁹⁵ http://vetoviolenecdc.gov/childmaltreatment/phl/resource_center_infographic.html

⁹⁶ Neuroscience, molecular biology and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. Shonkoff JP et al. *JAMA* 2009; 301(21): 2252-2259

In addition to an abiding commitment to children's health and well-being, our recommendations are guided by the following beliefs.

- Children's development to become healthy adults should be supported through prevention and early intervention services and supports. Families with risk factors for distress and impairment in the child should have access to, as well as support for engagement with, helpful resources that are community-based and culturally competent.
- Healthcare services should be organized and delivered in a manner that helps families and youth become better health consumers and builds their self-efficacy skills and independence. Healthcare providers must partner with families and transition age youth at all levels in the behavioral health care system.
- No one size fits all. Pediatric and family medicine practices vary in size, communities vary in available resources, and families, youth, and children have different strengths, needs, and cultures. Integration strategies must be sufficiently robust and flexible to address racial and ethnic disparities in access, treatment, and outcomes.
- Current investments and initiatives should be leveraged for their operational capacity and emerging promising practices. These initiatives include the Children's Behavioral Health Initiative (CBHI)⁹⁷, the Massachusetts Child Psychiatry Access Program (MCPAP)⁹⁸, the Patient Centered Medical Home Initiative (PCMH)⁹⁹, and the Child Health Quality Coalition (CHQC)¹⁰⁰.
- The move to integrated care will and should be an evolution. Moving from fee-for-service to alternative payment methods might require some short-term bridging strategies. Extending the empirical evidence base to support innovations and refinement of current precedents such as CBHI and MCPAP will take time and require systems that can adapt to emerging evidence about what works with the populations served.
- Pediatric behavioral healthcare costs and return on investment (ROI) are dispersed into other systems (e.g., schools, child welfare, juvenile justice) and into the future (e.g. physical health, substance abuse, prison, employment, parenting competence). However, the inability to fully capture that ROI to fund healthcare reforms today should not deter us from investing in improving the quality of children's healthcare. While the ROI within healthcare over the short term might be minimal, ROI to society as a whole over time and across generations will be substantial.

⁹⁷ <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/>

⁹⁸ Improving Access to Mental Health Care for Children: The Massachusetts Child Psychiatry Access Project. B. Sarvet et al. *Pediatrics* published online Nov 8, 2010; DOI: 10.1542/peds.2009-1340

⁹⁹ <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/>

¹⁰⁰ <http://www.mhqp.org/collaboration/chqc.asp?nav=063700>

RECOMMENDATIONS

In order to facilitate the BHTF's work, our recommendations are organized according to the six questions posed by the Legislature in Section 275 of Chapter 224. In some cases, we have taken the liberty of addressing the general issues raised, rather than specifics, in a manner that best applies to children and their families.

- I. The most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care.**

Integrating behavioral health services with primary care requires several structural mechanisms to bridge these two care delivery systems. We view the patient-centered medical home (PCMH) model and System of Care (SOC)¹⁰¹ models as compatible with each other and as strong platforms on which to build these integrating mechanisms.

We acknowledge that these mechanisms have not yet been established through empirical research as "effective and appropriate." However, there is expanding evidence and consensus from a variety of sources, including references cited in this document as well as innovators' experiences and the professional experiences of Council members, which has informed our deliberations. Implementation of these integrating mechanisms should include a strong research / evaluation component in order to assess their cost-effectiveness and to promote continuous quality improvement.

Care Integration Recommendations

1. Behavioral health screening, using evidence-based standardized tools, at every well child visit should be required and reimbursed for all primary care providers for all children up to age 21. When a PCP deems necessary, both a mental health screening and a substance abuse screening should be allowed in a single visit. Post-partum depression screening should be included in well-child visits for parents of children under six months in age. Primary care providers in the adult system should provide age appropriate behavioral health screening to their transition age youth patients.
2. Behavioral health consultation should be readily accessible to primary care providers. A range of arrangements supporting strong working relationships between behavioral health providers and primary care providers should be allowed. These arrangements include, but are not limited to, co-location.
3. Peer supports, including family partners with "lived experience" raising a child with behavioral health challenges and youth mentors, should be a standard

¹⁰¹ The System of Care Handbook: Transforming Mental Health Services for Children, Youth and Families. Stroul BA and Blau GM. Paul H. Brookes Publishing Co., Baltimore, 2008.

service that is readily available. Peer supports are critical for initial and on-going engagement of families and youth who might be reluctant to or lack knowledge about and/or skills for engaging with behavioral health care. Reimbursement should be sufficient to allow for ongoing coaching and support for the emerging workforce.

4. Care coordination should be a standard of care and reimbursed for all children receiving both primary and behavioral health care. For most children, the PCP’s on-going relationship means that they will be best able to provide care coordination. However, behavioral health providers might be better able to coordinate care for children with significant behavioral health conditions.

1. Behavioral Health Screening

The first step in integrating behavioral health care is identifying the need for it. Nationally, the average delay between onset of symptoms and biopsychosocial intervention for children is between 8 and 10 years – critical developmental years in the life of a child.¹⁰² Behavioral health screening using validated tools provides an effective, evidence-based approach for increasing early identification and intervention, which can both improve outcomes and reduce the costs of mental illness.¹⁰³

Since 2008, MassHealth has required and reimbursed PCPs to conduct behavioral health screening at well child visits (up to age 21) as required by Medicaid’s Early Periodic Screening Diagnosis and Treatment (EPSDT) provision. MassHealth established a list of clinically appropriate standardized screening tools from which providers select, based on the age of the child. The data below illustrate that it takes time to make significant progress and that, even with reimbursement available, screening does not occur at all visits for all children, as it should. Frequent public reporting and monitoring are important and should be expanded beyond MassHealth.

	Jan-March 2008		Jan – March 2011	
	% visits with BH screens	% BH need identified	% visits with BH screens	% BH need identified
< 6 months	8%	6%	43%	2%
6 mo to 2 years	17%	6%	73%	5%

¹⁰² Best Principles for Integration of Child Psychiatry into the Pediatric Health Home, American Academy of Child and Adolescent Psychiatry

¹⁰³ Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

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3 years to 6 years	18%	9%	76%	9%
7 years to 12 years	20%	11%	77%	11%
13 years to 17 years	18.5%	12%	71%	11%
18 years to 20 years	7%	24%	34%	11%
ALL	15%	11%	67%	8%

Source: CBHI website

For children under six months in age, the low screening rate has been explained by some as due to the lack of an appropriate screening tool. Primary care providers have advocated for the substitution of postpartum depression screening for a child mental health screen.¹⁰⁴ The Council recommends requiring and reimbursing post partum depression screening, in addition to developmentally appropriate screens, at well-child visits for parents of children under six months in age. Identifying and treating post-partum depression is critical. Postpartum depression has a significant adverse effect on young children’s cognitive and emotional development in the preschool years. Treating maternal depression improves the cognitive and social emotional development of young children even in the absence of any direct intervention with the child.¹⁰⁵

At the other end of the age spectrum, screening rates are likely lower among 18 to 20 year-olds because they are frequently seen in adult care, rather than pediatric settings, where providers are more often unfamiliar with the screening requirement.¹⁰⁶ The Council recommends educating primary care providers in the adult practices about the importance of behavioral health screening. In addition, reimbursement should be allowed for both a mental health screening and a substance abuse screening in a single visit. Currently, providers are limited to one screening and must choose between screening tools that do not cover both mental health and substance abuse.

¹⁰⁴ Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

¹⁰⁵ Children of affectively ill parents: A review of the past 12 years. Beardslee WR, Gladstone TRG, and O’Connor E. JI of Am Academy of Child and Adol Psychiatry, 50, 1098-1109, 2011

¹⁰⁶ Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

2. Behavioral Health Consultation

One quarter of pediatric primary care visits address behavioral issues.¹⁰⁷ When a behavioral health concern is identified, the primary care provider must have access to a behavioral health provider for (1) clinical consultation, if needed, and (2) connecting a child / family either for a brief intervention or longer term services. A licensed behavioral health provider should, ideally, be on site to provide “curbside” consultation to the primary care provider. These consultations might take as little as ten minutes. Access to psychiatric consults will likely be through a combination of on-site and virtual, since most primary care practices will not generate enough need to support a full-time psychiatrist on site.

Based on the consult, a referral might be needed for direct services. Some children will need only a brief intervention, which could be provided by the on-site behavioral health provider using a brief solution-oriented treatment approach. Other children will need longer-term care provided by a community-based organization. The on-site behavioral health provider or a care coordinator could locate an appropriate community-based provider and make the referral. The MCPAP teams include care coordinators for this purpose. [MCPAP is described below under “Telemedicine”.]

3. Peer Support: Family Partners and Youth Peer Mentors

Every healthcare professional has a responsibility to engage families and children in the care delivery process. However, engaging with families and children presents unique challenges. Unlike adults where engagement is with the identified patient, for children (the identified patient) engagement is primarily with the parents. Engaging parents around family behavior change and use of community supports can be challenging. Some parents don't think their young children could have a behavioral health problem, so they see no reason to consult a behavioral health provider. Some may view other needs in the family, such as employment, housing, childcare or transportation, as requiring priority attention before or concurrent with mental health treatment for their child and family. Others may be wary of involvement with the “system” based on previous negative experiences with providers. Others are burdened with their own medical, behavioral health and/or substance use disorders.

A variety of engagement strategies are necessary, with choices available to families. Some families may prefer to engage with professionals with expertise in subject matter

¹⁰⁷ Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. National Research Council and Institute of Medicine. Washington, D.C.: The National Academies Press. 2009

and exceptional family engagement skills. Evidence-based strategies for family engagement by clinicians and behavioral health settings have shown excellent results.¹⁰⁸ However, some families will benefit from and want the support of a person, a Family Partner, who has lived experience caring for a child with behavioral health needs. For older adolescents and young adults, young adult peer support, analogous to parent to parent support for parents, may be critical to promote the youth/young adult's engagement in care coordination and treatment.

A Family Partner service (called "Family Support and Training" services) and workforce has been built in the MassHealth system over the past five years. Family Partners are individuals who have raised children with special health care needs (usually behavioral health needs) and who have been specially trained to work with other caregivers. Initially, this service was available only to families whose children received intensive care coordination (ICC). Approximately three-quarters of the ICC users also accessed Family Partner services in FY2011. Based on numerous requests by families, this service has been expanded to cover families whose children receive in-home therapy or outpatient services without receiving ICC. Anecdotal evidence from MassHealth services shows extremely high family satisfaction with Family Partners and good success in engaging families who might otherwise not follow through with care.

On a smaller scale, MassHealth has funded "Therapeutic Mentor" services to support skill building and effective use of treatment by youth served within Intensive Care Coordination. As noted above, half of all lifetime mental illness develops by age 14 and three-quarters by age 24. Good behavioral and primary care at this age can change the trajectory of their adult well-being. Yet, as youth transition to adulthood, the safety net of family is receding leaving them to manage health risks on their own with limited experience with self-care (e.g., making or keeping appointments). Reaching out to and supporting transition age youth in accessing and engaging in behavioral health care is critical and deserves dedicated resources.

Peer supports have value even beyond their work with families and youth. They can be critical in promoting engagement by supporting cultural competence, by helping the workforce reflect the population served, as well as by serving as cultural "bridges" to other providers working with the family and youth. They can also help educate their healthcare colleagues and de-stigmatize behavioral health conditions by sharing their lived experiences.

¹⁰⁸ Integrating Evidence-Based Engagement Interventions Into Real World Mental Health Settings. McKay, M. et al. *Brief Treatment and Crisis Intervention*, Oxford University, 4, 2, 177-186, 2004.

The Council also endorses engaging families and youth beyond just the receipt of services for their children. Patient and family engagement should include patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, evaluation, and policy-making – to improve health and healthcare.¹⁰⁹

The Council lauds the Chapter 224 requirement that Accountable Care Organizations include a consumer representative in their governing structure. We recommend that ACOs appoint more than one consumer representative. At least one should represent families whose children receive both primary and behavioral health care and one should represent transition age youth. Examples worth noting include the Pediatric Primary Care Organization at Children's (PPOC), which is working with several of its practices to establish family advisory councils, and the PCMH Workgroup on Behavioral Health Integration and the CHQC Task Force on Care Coordination whose members include parents of youth with physical and behavioral health chronic conditions.

4. Care Coordination

Care coordination should be a standard of care for all children. We have benefited from the significant effort of our colleagues on the Child Health Quality Coalition in defining how care coordination functions as a key integrating mechanism. The Council endorses the definition of care coordination put forth by Dr. Richard Antonelli and his colleagues¹¹⁰:

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

The MA Child Health Quality Coalition's Care Coordination Task Force's Care Coordination Framework identifies a structure for implementing care coordination as a standard of care. The Framework was developed by a multi-stakeholder task force with strong family representation and builds on implementation experiences nationwide. It offers a foundational set of care coordination services that is broadly applicable independent of condition, severity/acuity, or age, including adults, with the obvious additions of references to schools and transitions from pediatric to adult care.

¹⁰⁹ Patient and Family Engagement: A Framework For Understanding The Elements and Developing Interventions and Policies, K. L. Carman, P. Dardess, M. Maurer, S. Sofaer, K. Adams, C. Bechtel, and J. Sweeney. *Health Affairs* 32. No. 2 (2013): 223-23.

¹¹⁰ Making Care Coordination A Critical Component of the Pediatric Health System: A Multi-disciplinary Framework. R. Antonelli, J. McAllister, and J. Popp. Commonwealth Fund pub no. 1277. May 2009

Key Elements of High-Performing Care Coordination Linked to Process, Structure, and Outcome Measures to Monitor Their Adoption

7. Needs assessment for care coordination and continuing care coordination engagement
8. Care planning and communication
9. Facilitating care transitions (inpatient, ambulatory)
10. Connecting with community resources and schools
11. Transitioning to adult care

Antonelli and colleagues delineate the following functions incorporated into care coordination. They also note that these functions are applicable across all ages (i.e., children and adults).

1. Provides separate visits and care coordination interactions
2. Manages continuous communications
3. Completes / analyzes assessments
4. Develops care plans with families
5. Manages / tracks tests, referrals, and outcomes
6. Coaches patients / families and promotes family engagement in treatment
7. Integrates critical care information
8. Supports/ facilitates care transitions across both settings and ages
9. Facilitates team meetings
10. Uses health information technology to organize care coordination activities

These functions could be performed by any member of a care team. Some (likely larger) practices might establish a dedicated care coordinator position. Others will distribute these functions among members of the care team. The competencies that are needed by whomever provides care coordination are:

1. Develops partnerships
2. Proficient communicator
3. Uses assessments for intervention
4. Facile in care planning skills
5. Integrates all resource knowledge
6. Possesses goal/outcome orientation
7. Approach is adaptable and flexible
8. Desires continuous learning
9. Applies solid team building skills
10. Adept with information technology

Instruments to assess the need for care coordination for behavioral health needs as well as the need to enhance patient or provider engagement (“activation”) are needed.

Examples of the former are the AACAP Child and Adolescent Service Intensity Instrument (CASII)¹¹¹ and the Patient Activation Measure.¹¹²

Locus of Care Coordination

For most children, it is the primary care provider who has an on-going connection and, thus, will be best able to serve as their medical home. However, there may be periods of time during which children with more intensive and chronic behavioral health needs could be better served by their behavioral health provider as their medical home. In fact, MassHealth is exploring how its 32 Community Service Agencies (CSAs) could serve as a health home (a special kind of medical home) for children with intensive behavioral health needs. A recent publication, "Customizing Health Homes for Children with Serious Behavioral Health Challenges", provides some helpful guidance on this, making the following points about how and why health homes are different from medical homes¹¹³:

- Health homes are intended for populations with chronic conditions, including those with serious behavioral health conditions, while medical homes are intended for every individual.
- Medical homes historically have focused on the coordination of medical care, while health homes are intended to build linkages to community and social supports and coordinate medical, behavioral and long-term care.
- Medical homes tend to use physician-led primary care practices as the coordinating entity or team. Health homes may use other types of entities, such as behavioral health provider organizations.
- General estimates are that two-thirds of the children served in intensive care coordination models like the CSAs are involved in child welfare and/or juvenile justice and sixty percent are involved with special education. The coordination among these systems along with behavioral health services consumes most of the care coordinators' time rather than the interface with primary care.
- This extensive systems involvement as well as the need to work closely with caregivers creates a complexity that has implications for care coordinator staffing ratios and qualifications as well as reimbursement rates.

Design and Operational Flexibility

¹¹¹ www.AACAP.org

¹¹² www.insigniahealth.com/solutions/patient-activation-measure

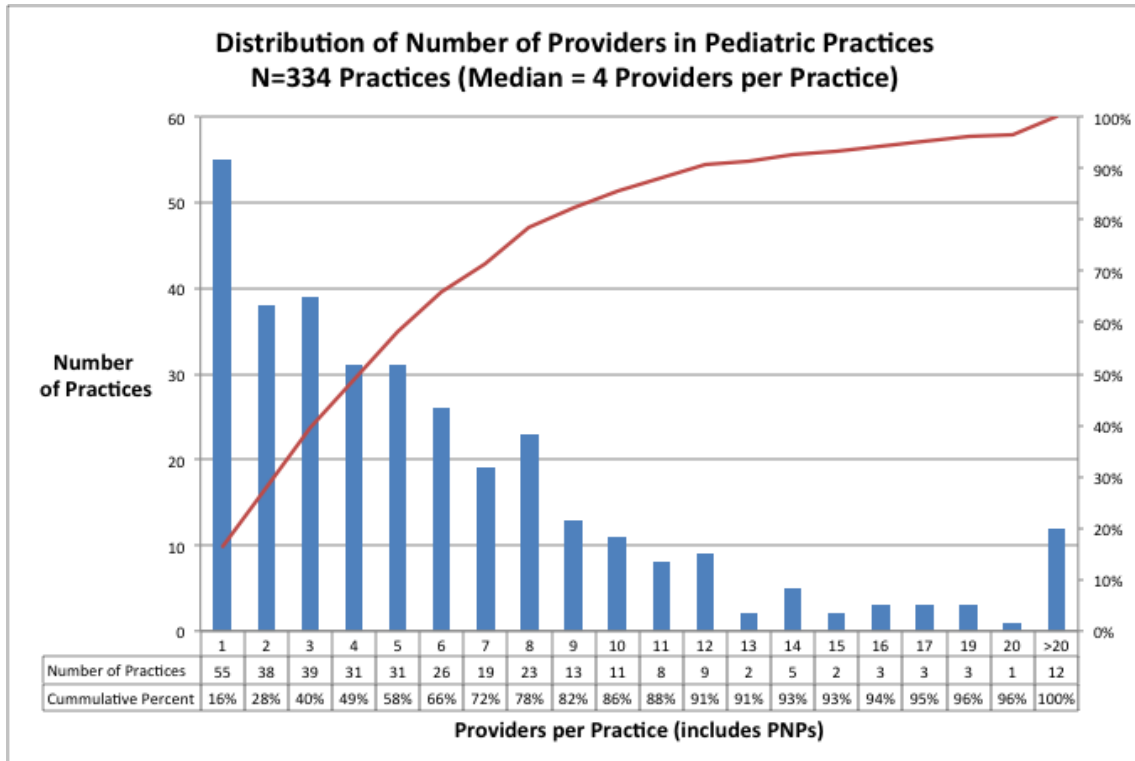
¹¹³ Customizing Health Homes for Children with Serious Behavioral Health Challenges. Sheila Pires. March 2013.

It is difficult to predict how many behavioral health providers, care coordinators, and peer partners would be needed at a PCP practice, an ACO, or system-wide. We asked our guest experts about the ratio of these staff to a primary care pediatrician's caseload within their practices. They generally estimated five primary care pediatricians would generate a full time workload for one care coordinator, but cautioned that testing and refinement of processes and relationships is needed. The demographics of the population served by each practice or ACO will have significant impact on the care coordinator and peer partner capacity needed. For minority populations and/or families living in poverty, there will likely be a relatively greater need in order to reduce disparities in access, treatment, and outcomes.

The varying size of primary care practices indicated in the chart below means that a number of arrangements will be necessary. These arrangements include: coordinated but not co-located, co-located and coordinated, and co-located and fully integrated. Small group practices and solo practitioners will likely need to develop arrangements to share capacity. Even a medium-sized group practice might not be able to afford a dedicated care coordinator but rather have a behavioral health specialist and peer partner share care coordination responsibilities. MCPAP is a good model for sharing capacity virtually. The CSAs could provide a base of support for Family Partners and Youth Peer Mentors, as they currently do for CBHI Family Partners.

Several experts shared with us the benefit of co-location in allowing a primary care provider to introduce the family/child to a behavioral health specialist, noting that a referral from a trusted provider increased comfort level with a behavioral health provider. They also noted the strong working relationships that develop because of co-location. They were careful to note that care coordination and co-location do not necessarily mean that care is integrated. Co-location eases integration, making it more likely, but doesn't guarantee it.

There is no single model of primary care and behavioral health care integration that addresses all levels of need for treatment and care coordination. Care coordination, which is the key process for integrating care, should not be defined solely by its physical location. Primary care providers will need to be able to develop effective relationships with family therapy teams and with care management entities to support a significant portion of their patient populations. **Attachment A** provides vignettes of three children, their families, and their healthcare needs that illustrate the range of integration arrangements that will be needed in a well-functioning system.



Data from the MCPAP database. Provided courtesy of the Massachusetts Chapter of the American Academy of Pediatrics

Telemedicine

Given the varying sizes of pediatric practices, telemedicine will be an important mechanism to support integration. Small PCPs will likely need to access behavioral health consultation, peer supports, and care coordinators virtually.

The Massachusetts Child Psychiatry Access Project (MCPAP) solves this problem by providing primary care clinicians with virtual access, via telephone, to child psychiatry consultation. Funded by the Department of Mental Health and managed by the Massachusetts Behavioral Health Partnership, MCPAP is comprised of six regional teams of 1 FTE of a child psychiatrist, 1.5 FTE of a licensed social worker, and 1 FTE of a care coordinator. The regional focus helps foster relationships between PCP practices and their MCPAP team and promotes a teaching orientation. The program is designed to give primary care providers consultative support to manage children with less complex behavioral health needs, freeing the limited child psychiatry workforce to manage children with more complex needs. Services include: answering a PCP's diagnostic or therapeutic question, assistance in accessing behavioral health services, transitional care until those services begin, and acute psychopharmacologic or diagnostic consultation. PCPs may access MCPAP for any child regardless of insurance

type; more than half of the encounters are for privately insured children.¹¹⁴ Commercial insurers have resisted requests to pay their fair share for MCPAP; we recommend that they be required to do so.

Workforce Development

Our Council membership represents a range of disciplines, each one committed to working through the challenges of primary and behavioral health care integration. We recognize that each of our disciplines has its own language, practice culture, professional licensure, and professional development resources.

Whether working on an integrated team, co-locating, or coordinating care between two provider sites, all primary care and behavioral health providers will need to become “bi-lingual”, able to speak the language of both the primary and behavioral health care systems. Behavioral health specialists who work in primary care practice will likely be the solo practitioner and thus need to be a seasoned and skilled professional. Primary care practices will need to be welcoming and supportive of behavioral health providers.

We encourage the training programs and credentialing bodies of each discipline to take a leadership role in preparing and supporting professionals to collaborate with colleagues in order to deliver integrated care. Training programs to produce skilled behavioral health specialists to work in primary care settings are needed, as are training programs for pediatricians in working with behavioral health specialists. An example is the AACAP “Toolkit in Training for Systems-Based Practice” developed to support training of child and adolescent psychiatrists in these areas.¹¹⁵ Licensing boards for the behavioral health professions should review licensure statutes and regulations to ensure that they do not create obstacles for training and supervised practice in innovative settings and practice models.

Ongoing professional development and learning opportunities will be needed to help health care providers continue to develop their abilities to work in an evolving integrated healthcare system. Continuing education requirements (e.g., CEUs) must reflect the specific knowledge and competencies needed to be an effective practitioner. In addition to formal training, real-time learning opportunities and communities of practice will be important. Payment methods and productivity expectations must allow for the time to participate in these opportunities.

Peer supports need specific training and ongoing coaching and supervision, as well as a “home” where they can support each other. Accreditation for peer support specialists is

¹¹⁴ The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care. Wendy Holt. Commonwealth Fund pub. 1378, Vol. 41. March 2010.

¹¹⁵ http://www.aacap.org/cs/root/physicians_and_allied_professionals/training_toolkit

supported the National Federation of Families for Children's Mental Health.¹¹⁶ Resources are needed to develop this new workforce.

Performance Measurement

The Council believes strongly in the importance of outcomes. Ultimately, the significant effort and investment in integrating primary and behavioral health care is worthwhile only if it results in better health and wellbeing outcomes for children. We believe that the integration mechanisms that we recommend will do so; however, we acknowledge that they have not been rigorously studied and should be. Thus, we recommend that initial efforts focus on measuring and studying the quality and cost effectiveness of any integration mechanisms used. We need to know how these mechanisms are operating in order to understand their impact on quality, cost, and outcomes. The Council points to work of the Child Health Quality Coalition in inventorying measurement domains as a useful starting place for developing and testing measures of care coordination. Since care coordination measurement is in its earliest stages of development, we recommend that measures be promoted for usability and feasibility testing prior to requirements for pay-for-performance.

We also recommend measuring key process milestones towards good clinical outcomes (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, family and youth satisfaction). Payers should invest in creating a culture of reporting by providing incentive payments to providers for collecting and using data to improve their performance. Reporting should allow providers to demonstrate their quality, especially those in new areas of performance, as well as to identify areas needing improvement.

Linking Pediatric Care with Care for Parents

Parents of children with a behavioral health condition are often under great stress and /or burdened with their own physical and/or psychological disorders. This can impede their ability to fully care for and to manage care for their children. Care coordinators and family partners can help the parent become more aware of how their unmet healthcare needs may adversely impact their best efforts to care for their children. Care coordination for children's health care should be prepared to develop linkages with the parents' medical care, in conjunction with the parent and the child's PCP, as needed.

- II. How current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes.**

¹¹⁶ <http://certification.ffcmh.org/resources>

Our advice and recommendations come at a time of significant transition in healthcare payment methods. Some health insurers have already or are in the process of implementing alternatives to the traditional fee-for-service payment methods. We see great potential in using payment methods as a means to facilitating integration and achieving higher quality. We caution against using payment methods simply as a means to drive down costs. Investing in quality will be cost-effective over the long term. That said, we anticipate that fee-for-service payment will exist for a while longer, whether at the provider organization level or at the individual practitioner level. Therefore, our recommendations are intended to address both traditional and emerging payment methods.

Whether by supplementing fee-for-service rate schedules or by incorporating an alternative payment method, the integration mechanisms described above must be reimbursed / funded in order to achieve cost effective, quality care for children. In addition, reimbursement barriers to primary and behavioral care integration must be reduced so that we can learn what the service need really is and what it will take to deliver it. The real cost of behavioral health services is not currently known since behavioral health services have historically been under-utilized and underfunded. We caution against developing alternative payment methods that include behavioral health in a comprehensive rate until there is sufficient data available to inform utilization and pricing targets. Aligning billing requirements with the routines of integrated care, rather than with separated primary and behavioral health care as they are now, will help reveal actual need and cost.¹¹⁷

- Care integration services should be reimbursed as a bundle that incorporates the ten functions and the CHQC care coordination framework elements listed above. PCP practices will need leeway to determine the best way to staff those functions, given the size of their practice and the potential partners and resources available in their communities.
- All payers should be required to reimburse pediatric primary care providers for administration, scoring, and interpretation of behavioral health screening at every well child visit. Providers should not be limited to one screening per visit, as is the case currently. If they deem necessary for assessing a youth's health, they should be reimbursed for conducting both a mental health and a substance abuse screening. In particular, reimbursement for behavioral health screening should be mandatory for any adolescent who screens positively for substance use disorder (SUD), given the very high rate of co-morbidity of a mental health diagnosis in the context of a SUD.

¹¹⁷ The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

- All payers should be required to reimburse pediatric primary care providers for administration, scoring, and interpretation of post partum screening in pediatric well child visits for parents of children under six months in age.

- Several other changes are needed to make it possible to support and refine the integration of primary and behavioral health care.^{118 119}
 - Eliminate any restrictions on same-day billing between behavioral health and primary care providers.
 - Allow both primary care and behavioral health providers to bill for overlapping time.
 - Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day.
 - Allow for brief intervention services to be billed before a full assessment is completed.
 - Allow for units of billing to be as short as ten minutes to reflect the brief consults that will be needed.
 - Set rates for consultation time to a PCP commensurate with rate for psychotherapy direct service.
 - Pay primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without their child present when the focus of the visit is the child's healthcare needs.

- Reimbursement methods should support the adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment services. An effective system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care. Parent training programs have a particularly strong evidence base and we call attention to two: the Family Talk Preventive Intervention and the Positive Parenting Program (Triple P). Developed by our colleague and Council member Dr. Beardslee, Family Talk is designed to help families identify the effects of parental depression, share individual experiences with parental depression, build on family strengths, improve family communication about depression, build coping skills and develop strategies to promote resilience in parents and children.¹²⁰ Triple P gives parents simple and practical strategies to help them confidently manage their

¹¹⁸ The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

¹¹⁹ Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

¹²⁰ <http://fampod.org>

children's behaviors, prevent problems from developing, and build strong, healthy relationships.¹²¹

- We recommend measuring structure and process (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, family and youth satisfaction) before paying for outcomes. Managing any alternate payment method will require good measurement of process and proximal outcomes. It also requires fully defining care coordination and measuring when it is occurring as appropriate in order to assess its contribution to improved outcomes.
- Children will vary greatly in the amount of care coordination they require. Payment mechanisms need to accommodate this variation and must be structured so that payers and providers share risk for the cost of care, particularly for children with complex health needs and costs. Care coordination for children with modest needs for care coordination might be paid through a PMPM rate to the PCP, for example, while children with intensive needs requiring dedicated, low-caseload care coordination might receive this through a per diem rate.
- Establishing rates for a new service model, without a payment or utilization history, is hard to get right the first time. There must be sustained commitment and effort to review and adjust rates to ensure that they support both the service standards and the organizational supports required to manage the services (e.g., information technology). Insurers and providers must work together to review and adjust payment rates and/or methods to ensure high quality care is provided in a cost-effective manner.
- In addition to alternative payment methods for healthcare, it might be fruitful to explore alternative financing methods across child-serving systems. There are two points of access for children to receive behavioral health care services: pediatric primary care and schools. However, funding is siloed and healthcare reform doesn't impact some of the financing sources for school-based care. Some school-based care is provided by community-based agencies and reimbursed by insurance, while some services are provided directly by school personnel and financed by the school (e.g. municipal Medicaid, Federal grants). Methods that integrate healthcare financing across child-serving systems might allow for even more effective healthcare delivery integration and reduced healthcare costs.

III. The extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols.

Parity

Ensuring that behavioral health treatment is covered in the same way as treatment for physical health conditions, as legally mandated, is a critical foundation for the integration of behavioral health and primary care. Clear guidance for both providers and consumers and enforcement regarding parity will remain necessary as new health care delivery arrangements are developed. We support the numerous recommendations

¹²¹ <http://www.triplep-america.com/index.html>

that our colleagues leading the Children's Mental Health Campaign have provided to the Division of Insurance.

Achieving Chapter 224's quality and cost goals requires a broader view of what it means to treat behavioral health and physical health conditions on par with each other. Focusing solely on the amount of services will not be sufficient as primary care providers become dependent on the quality of and access to behavioral health services. Quality behavioral health services can help improve primary care outcomes and costs if they are broadly available as well as reimbursed sufficiently and in a manner that allows them to be delivered as we have recommended in this document.

First, there must be a full array of community-based behavioral health services available to children and families regardless of where they live and what health insurance they have. Currently, MassHealth offers a richer array than do private insurers. Commercial insurers will need to offer an equally rich array in order to achieve quality and cost outcomes for children.

Second, parity also needs to include support for behavioral health interventions (e.g. talking to the patient or family) at a rate based on time and complexity commensurate with rates that support physical health interventions. For example, PCPs should not continue to be reimbursed more for the few minutes required to freeze off a wart than a half hour talking with the child or parents about a behavioral health issue such as the impact on the child of parental divorce when parents are putting the child in the middle of their conflict with each other. Reasonable rates will help ensure a sufficient number and range of behavioral health providers and services.

Choice

The Council believes strongly that families should be able to choose their healthcare providers. However, we recognize the tension between the value of according broad choice to families and the strategy of co-locating primary care and behavioral health.

Allowing families to choose to receive behavioral health from a provider that does not have a relationship with their PCP undermines the integration mechanisms that we recommend above. In an integrated system, when families choose a primary care provider, they will increasingly also be choosing a behavioral health provider.

Therefore, they should have access to information about how primary care providers integrate behavioral health services, how this might impact their children's care, and the expected benefits of coordinated or integrated care. Our hope is providers will offer primary care and behavioral health care services that are so responsive to and effective in meeting families' needs and concerns that families will choose these new integrated

arrangements. Peer supports can help families understand their options, and make well-informed choices, and be educated consumers of these new health arrangements.

IV. How best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services.

We believe that the functions and positions described in our response to Question I are key strategies for helping primary care providers recognize behavioral health conditions and to make appropriate referral decisions. Using standard screening tools to identify behavioral health concerns, consulting with behavioral health providers, and working with peer supports and care coordinators to access appropriate services are important patient-level strategies.

There are strategies at the macro level as well. First, professional development and licensure /credentialing bodies must reflect the knowledge and competencies required to be effective in a more integrated healthcare system. Experts in integrated care delivery could identify specific topics and competencies. Second, primary care providers will need to establish clear referral pathways and relationships with community providers. PCPs will need knowledge about and confidence in the organizations to which referrals could be made. Primary care and behavioral health care providers must work together to ensure that the right service capacity exists to meet the needs of children and their families. This means that the behavioral health service array should be equally robust as physical health services.

V. How best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness.

The co-morbidity issues for children are different from those of adults with serious mental illness. Children with serious behavioral health challenges do have high rates of expensive co-morbid physical health conditions. Recent estimates suggest that about one-third of Medicaid-enrolled children who use behavioral health care have serious medical conditions, principally asthma. However, Medicaid expenditures for children who use behavioral health care – even the most expensive of these children – are driven more by behavioral health service use than by use of physical health care – in contrast to the adult population.¹²²

For children, the issues of concern are more often in reverse: it is the effect of emotional or psychological trauma, or toxic stress, on their physical health over their lifespan into

¹²² Customizing Health Homes for Children with Serious Behavioral Health Challenges. Sheila Pires. March 2013.

adulthood about which healthcare providers need to be educated. There is ever-expanding basic science research demonstrating how ongoing stress of sufficient intensity can cause enduring changes in brain maturation across childhood into young adulthood. The most compelling evidence of this impact has been produced by the landmark Adverse Childhood Experiences (ACE) study. The ACE Study is a decade-long and ongoing collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC).

Adverse Childhood Experiences (ACEs) include 10 types of adverse childhood experiences: childhood abuse (emotional, physical, and sexual abuse), neglect (physical and emotional), and family dysfunction (growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, a parental separation/divorce, or a family member incarcerated). Over 20% of respondents experienced three or more categories of trauma, or ACEs. The ACE Study examined the relationship between these experiences during childhood and reduced health and well-being later in life. It showed dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of death.

As the ACE Study gains traction across the nation, some states have collected statewide, population level ACE data gathered through the Behavioral Risk Factor Surveillance System (BRFSS). The MA Department of Public Health should explore the feasibility of incorporating the ACE questions in its annual BRFSS survey.

Investing in Wellness

According to the National Academy of Sciences, several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral disorders are greatest by focusing on young people. Interventions before the disorder occurs offer the greatest opportunity to avoid the substantial costs to individuals, families, and society that these disorders entail.¹²³

Chapter 224 created a Prevention and Wellness Trust Fund, administered by DPH in collaboration with the Prevention and Wellness Advisory Board. All activities paid for by the fund must support Massachusetts's goal to meet the health care cost growth benchmark and have at least one of the following functions: reduce the rates of common preventable health conditions; increase healthy habits; increase the adoption of effective

¹²³ Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. National Research Council and Institute of Medicine. Washington, D.C.: The National Academies Press. 2009

health management and workplace wellness programs; address health disparities; and build evidence of effective prevention programming. The Commissioner of DPH must award at least 75% of the fund each year through a competitive grant process to community-based organizations, health care providers, health plans, municipalities, and regional planning agencies. The Commissioner can give priority to proposals in geographic areas with high need.¹²⁴

DPH should take a strategically long-term approach to managing this Wellness Fund by investing, in part, in children's well-being. The Council recognizes that responding to ACEs and childhood trauma is not solely the purview of the healthcare system but also of the broader social services and public health systems. This Wellness Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations. It could utilize ACE data, along with other sources, to guide its grant-making and leverage existing initiatives that incorporate a trauma-focus into service delivery. Wellness Fund investments should be studied for their ROI.

VI. The unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

The Council recognizes that all of the above strategies for integrating care will have little impact if health information cannot be shared among all providers on a care team (regardless of physical location). We fully acknowledge the tension that exists between promoting communication among all members of a child's care team and ensuring that confidentiality and privacy protections are in place. Our colleagues on the Child Health Quality Coalition's Communication and Confidentiality Task Force are identifying issues impacting communications and confidentiality across the Coalition's stakeholder groups as well as resources that can help address those issues. The Council supports their emerging recommendations, provided in Attachment B.

One of the unique factors with respect to children exists in the relationship between healthcare providers and school-based health services. Exchange of information between the two is both critical and challenging. Recent conversations among DMH, DCF, and parents indicate that parents might be comfortable sharing information about a child's behavioral health issues/care with a school as long as it is for a specific purpose; however, they don't want to share the entire family history. In addition, there are legal issues regarding consent to the sharing of information by parents and/or

¹²⁴ Summary of Chapter 224 of the Acts of 2012. Anna Gosline and Elisabeth Rodman, *Blue Cross Blue Shield of Massachusetts Foundation*. September 2012

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young people that must be resolved. Consent by the parent(s) may be sufficient in one context, but consent by the parent and consent/assent by the young person may be required in other circumstances.

ATTACHMENT A: Three Vignettes Illustrating Primary Care and Behavioral Health Integration

The following three vignettes illustrate pediatric primary care and behavioral health integration at different levels of intensity of care coordination. We believe that family-driven care coordination, at all levels of intensity, is the key element of service integration as experienced by the youth and family. These vignettes are fictitious and are not based upon any specific child or family.

These vignettes are meant to demonstrate how a well-functioning system might respond to various levels of family need for care coordination. The system should meet whatever level of need the family experiences. We do not mean to suggest that there should be three fixed models or that families should be assigned to fixed tiers of service intensity.

Sara

Sara is an 11 year old fifth-grade girl seen in a group pediatric practice. Her mother brings Sara to see her PCP with a chief complaint of recurrent headache of recent onset. Sara has always shown signs of shyness, and recently has been complaining of headaches, often on school mornings. On these mornings she refuses to go to school. Sara has also been coming home from school in tears saying the other kids make fun of her; this is not altogether new but is happening more often this year. Sara is highly verbal and historically has been very successful academically, but sometimes appears to be "off" in her social interactions. She's also beginning to have difficulty in some of her academic subjects. Sara is medically well and appears to have no notable family or neighborhood stressors. Her 8 year old sister is doing fine.

Sara's mother is worried about Sara's headaches as she herself has a history of debilitating migraines (for which psychotherapy was prescribed but was not perceived as helpful). She is also concerned about Sara's social frustration and newly emerging academic problems.

Sara's mother brings her to her PCP with the complaint of recurrent headache and stresses at school. The PCP suspects that Sara's recent headaches and school refusal are related and after conducting a physical exam defers further medical workup. The PCP practice is large enough, with 7 FTE primary care clinicians, to support a full time on-site psychologist who has a policy of being interruptible for PCPs "warm hand-offs". The psychologist provides training, curbside consults with PCPs, and offers assessment and brief treatment for patients like Sara with relatively simple and mild to moderate behavioral health conditions. He also makes referrals to community BH providers for children with more complex or acute conditions, and coordinates care of those children with those providers. In this case, the psychologist meets briefly with Sara and her mom and arranges a return appointment later in the week. Although Sara's mom is concerned about a possibly serious headache syndrome that might require further medical evaluation, she finds it easier to accept a psychological consultation with a provider to whom

she has been already introduced by Sara's PCP, and who offers a quick follow-up consultation in PCP office.

The psychologist meets with Sara and her mother the following week. He, Sara, and Sara's mother are quickly able to agree that fifth grade is proving a stressful year for Sara and that she might benefit from learning some new skills to manage stressful moments. Over the next four months he meets six times with Sara and with Sara's mom or dad, teaching relaxation skills to Sara and the parents. He also suspects that Sara has some deficits in cognitive processing of social cues, and helps her parents request an evaluation of Sara for special education services. They are eager consumers of medical information and gladly read materials he provides on non-verbal learning disorders. He has time for several phone calls with Sara's school to assist in setting up her evaluation, and phone calls to her parents to coach them through the process of having Sara testing and IEP process. He also suggests to her parents that they explore some social skills groups in the community and he provides reference materials for two programs. With the parents, he is also able to explore with the school whether Sara is being bullied at school.

School testing reveals that Sara does has some cognitive deficits that affect her reading of social cues, and of her own emotions, and that could affect her developing awareness of her own psychological functioning. The school offers special educational support with organizational tasks, and a social skills group. The school adjustment counselor also works with the Sara, Sara's parents and the school nurse to develop and support strategies that Sara can use when feeling "stressed out" by peer issues or academic challenges. The school acknowledges that some bullying has occurred and includes a component in Sara's IEP to provide greater supervision and intervention if bullying occurs.

Commentary on integration with Sara:

Sara has a mild / moderate level of behavioral health acuity, and some complexity evident in the involvement of a non-medical service sector (education). It is clear that her difficulties could quickly escalate without the help provided in this scenario. The care Sara receives is timely and appropriate, and receiving counseling in the PCP setting may also reassure Sara's mother that the medical aspect of Sara's headaches is not being ignored. Sara's parents are willing consumers of the education offered by the co-located psychologist.

The co-located practice model in this illustration is drawn from Dr. Glenn Focht's description of a very promising model being piloted at PPOC. This model is designed to work for practices with at least 6 PCPs; if Sara's PCP belonged to a smaller practice, full co-location would not be practicable. Also, if evidence arose that Sara would work better with a female therapist, or if cultural or linguistic factors favored a behavioral health clinician with different competencies, her behavioral health care would need to be referred out. This model is based on behavioral health services lasting for a short duration and not requiring a high level of care coordination as the behavioral health clinician is expected to see 15 (out of a total caseload of 30) new cases per

week. Fortunately, Sara's need for treatment and care coordination in this illustration fit within these requirements. In general this model for integration appears to work best with children and families with relatively low acuity and complexity, and might be especially helpful when behavioral health problems have a strong somatic component. While medication was not considered for Sara, the co-location of the psychologist and the PCP could have helped to facilitate communication with a consulting psychiatrist if this had been needed.

Kalina

Kalina is an 11-year old girl attending sixth grade at a suburban middle school. She lives with her mother and younger brother and sister and has weekend visits to her father in another town, which she usually enjoys. Kalina is medically well, has routine PCP well child visits, and no behavioral health services. Her mother, to whom Kalina has historically been very close, is undergoing treatment for cancer and Kalina's two maternal aunts are frequently in the home to help out and to supervise the kids when Kalina's mother needs rest. Kalina's mother is worried she will lose her full-time job due to medical absence and has shared this with Kalina. Kalina is bright and has always been successful in school. She often tries to dominate her younger sisters and seems to compete with her aunts for control when they try to help out. Kalina's mother is more angry than usual with Kalina's father and when Kalina visits her father she rebuffs his attempts to cheer her up, and increasingly feels cut off from him. She also feels worried because her father has been sober for two years and she fears he will relapse if she upsets him.

Kalina's teacher has become concerned about changes in Kalina's behavior: she seems increasingly irritable in class, has gotten into feuds with other girls, which in one case erupted into a physical fight, and her journals and poetry contain explicit suicidal imagery. She has also gotten into confrontations with a couple of teachers and is not turning in her work consistently. Last week she confided to her teacher that one of her aunts had repeatedly slapped her; the school nurse filed a 51A. A DCF worker contacted the PCP seeking information and trying to determine how to help Kalina and her family. Later the PCP learns that DCF has screened out the report of abuse.

Commentary on integration with Kalina:

Kalina's situation is not unusual: a child with no recent history of behavioral health care but with fulminating behavioral health problems. Although the child and family have many strengths, things seem to be falling apart. Clearly Kalina has need for psychological support, but there are also family needs that must be addressed. The mother's medical crisis has realigned the family hierarchy resulting in disruption of Kalina's relations with her aunts, her father, her peers, and teachers. Initiating individual therapy would not address the family needs that are precipitating Kalina's behavior changes.

The well-targeted intervention of limited intensity and duration that works for Sara (behavioral health clinician co-located within the PCP practice) will probably be insufficient for Kalina. Kalina needs resources mobilized quickly and intensively to assess the family situation, address concrete needs, and provide rapid treatment to de-escalate and stabilize the developing crisis.

Someone needs to open a conversation immediately with Kalina's mom and Kalina, leading to subsequent conversations with Kalina's aunts, father, and siblings. In-home visits may be the best way to accomplish this. They must also get consent to talk with the PCP, DCF, and Kalina's school to understand her support system. Then they must be able to develop a plan with Kalina's mother that can unite various stakeholders in working to support the family through the crisis.

Unlike Jacob (the vignette below), with his long history of problems and his need for long-term planning and coordination, Kalina and her family need a rapid mobilization of resources including both treatment and care coordination. This type of resource is typically provided by a family therapy team with the capacity to do intensive outreach. Currently, MassHealth provides this resource through the In-home Therapy service. Some commercial plans pay for similar services, particularly on an individually-negotiated basis. Usually such teams are located in organizations that provide other behavioral health services.

A co-located clinician in a PCP practice will probably not have the time needed to meet Kalina's needs. However, PCPs could contract with behavioral health teams to provide treatment and coordination for their clients with high-intensity treatment need. The behavioral health team would maintain close contact with the clinician in the PCP practice throughout Kalina's treatment and while stepping her down, eventually, to less intensive treatment.

Jacob

Jacob is an 11-year old boy, attending fourth grade at his local public school, adopted at age 8 through the Department of Children and Families. His adoptive family was previously his foster family; he has two adoptive siblings who are in their late teens and functioning well. Jacob has a long history of special educational services and behavioral health services including six stays in institutional settings (inpatient hospitalization twice, CBAT three times, and a DCF STARR program once). Jacob has a full-scale IQ of 85, is believed to have had significant fetal alcohol exposure, is of very short stature for his age, and is about two years behind grade level in reading and math. He is an affable and outgoing boy who is somewhat impulsive and inattentive and has difficulty following complex verbal instructions. He loves sports and with some support has been able to participate with great enthusiasm, despite being small, in his town's youth football program. He has occasional contact with his birth mother, which is regulated by his adoptive parents, and which often results in some behavioral decompensation. Jacob's adoptive parents and therapist agree that these contacts, while stressful to Jacob, are also very important to him and should be facilitated when possible.

Historically Jacob has responded to stress and loss by running away, exploding with rage, and fabricating stories (confirmed untrue) of being abused. Since becoming adopted his behavior has stabilized considerably but his parents worry about his transition into adolescence and his ability to maintain a place in a pro-social peer group. After a CBAT admission last year, following particularly disruptive contacts with his birth mother, Jacob began boasting in school about drug use and sexual exploits, narratives that he apparently acquired from peers at the CBAT.

Jacob is medically well and has had extensive medical workups for his short stature in the past, as well as neuropsychological assessment and psychiatric evaluations for medication. Despite concerns about his growth, he is currently on a regime of Adderall managed by his pediatrician. He has a counselor at a local clinic who has known him for two years and also consults frequently with his parents. During the past three years he has also had In-home Therapy, Intensive Care Coordination (ICC), and Therapeutic Mentoring at various points through his MassHealth plan. While in ICC, Jacob's family was connected with a Family Partner who has continued to work with them even since graduating from ICC eight months ago. ICC helped to bring together all the known information from Jacob's complex history, to prioritize the family's goals for treatment, and to organize a plan of care that coordinates multiple services and supports (including medical services, Crisis Intervention, and CBAT discharge planning), putting the family in the driver's seat as much as possible. The family continues to work on the goals although no longer actively involved in ICC. The goals include: repeating Jacob's neuropsychological evaluation and meeting with the school to consider plans to help him catch up on critical academic skills; finding positive social and peer supports through sports, church and extended family; reevaluation of his medication on a regular basis. The family considers their Family Partner to have been one of the most significant components of the CBHI system in helping them learn to be empowered consumers who understand how to communicate effectively with other system partners, becoming as a result more independent and self-sufficient in managing Jacob's care.

Commentary on integration with Jacob:

Jacob is a boy with moderate acuity, high complexity, and a fairly strong support system. He is likely to have significant emotional / behavioral challenges during every major life transition or period of loss. Although he has had some medical concerns relating to his short stature, most of his medical services have been behavioral health services, and his care has been coordinated primarily by behavioral health providers (previously ICC and Family Partner, currently outpatient therapist and Family Partner).

The care coordination that integrates medical and behavioral care for Jacob is based on the model of CBHI services for MassHealth members (age birth to 21). Intensive Care Coordination provides a high level of care planning and care coordination, referring to other services for treatment. When the child's need for intensive planning and coordination declines, this function can shift to another level of care (such as outpatient, in Jacob's case). In this model the PCP is an important partner in the process, while the locus of planning and coordination lies outside the PCP. Strengths of this model include the ability to deal with children and families with very complex needs (cultural and linguistic competence, crisis management, extensive efforts to engage the family and natural supports, liaison with state agencies and schools), and a very strong emphasis on culturally-informed family-driven care. The use of an external organization which is dedicated to care coordination and provider Family Partners gives the PCP an enormous resource for supporting and following the most complex and high risk

children and their families. Challenges inherent in this model include the fact that it is not currently supported by commercial payers, the systemic need to train more behavioral health workers in the novel and demanding model of Intensive Care Coordination, and the need for primary care to develop relationships and role understanding to work effectively with external care management entities.

Summary comments

These vignettes suggest that there is no single model of primary care and behavioral health care integration that addresses all levels of need for treatment and care coordination. A co-located behavioral health clinician in a primary care practice is convenient for the PCP and can help with the large number of PCP clients who need a relatively light level of behavioral health intervention and coordination. Depending on the population served by the practice, however, there will be a segment whose needs are not fully met by this model. This includes children and families who need services mobilized intensively and quickly, and children with long-term needs for coordination of care for complex needs. Cultural complexity and caregiver impairment also create needs that are not easily met by brief intervention.

As a result, care coordination, which is the key process for integrating care, cannot be defined by its physical location. PCPs will need to be able to develop effective relationships with family therapy teams and with care management entities to support a significant portion of their patient populations. Internally located behavioral health clinicians can facilitate those relationships but cannot take their place. External care management resources will help PCPs with family engagement, with mobilization of appropriate levels of treatment and care coordination resources, and with community engagement to meet families' non-medical needs.

ATTACHMENT B:

**MA Child Health Quality Coalition
Communication and Confidentiality Task Force**

Suggestions for the Behavioral Health Integration Task Force Recommendations
on Confidentiality/Privacy Issues

(3-18-13)

The MA Child Health Quality Coalition has an active Communication and Confidentiality Task Force created to support its work promoting improved care coordination for children in Massachusetts, including addressing special issues for children with behavioral health needs.

Task Force Objective: Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.

This Task Force has been identifying issues impacting communications and confidentiality across the Coalition's different stakeholder groups and identifying resources that can help in addressing those issues. Based on the task force work to date, the following recommendations for confidentiality and privacy considerations should be considered:

(1) Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

(2) Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

- Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages.
- Provide guidance on the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.).

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- Strategies that encourage information sharing (e.g. "opt out") still need safe guards that ensure informed consent.
- Special issues of confidentiality must be considered for adolescents
- Peer networks offer important opportunities to support youth in understanding privacy protections and promote **strategic sharing**

(3) Sharing behavioral health information with families/youth can improve accuracy and patient safety.

(4) Look at privacy as a whole, not just within electronic health records.

Recommendations on Confidentiality/Privacy Issues for Behavioral Health Integration

Expanded Detail on CHQC Task Force Input from Child/Adolescent Perspectives

Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

- Leverage work already done that identifies the communication needs in a way that will transfer just enough information. See for example:
 - o *Combined MCE Behavioral Health Provider/Primary Care Provider Two-Way Communication Form* in use for children receiving services under the Children's Behavioral Health Initiative.
 - o *Re-entry planning for students returning to school following hospitalization for a behavioral health crisis* developed by the MetroWest Foundation/Framingham Public Schools and the Brookline Resilient Youth Team.
 - o *Boston Public Schools Superintendent's Circular on Sharing Student Health Information* that offers guidance including expressing all diagnoses, especially those related to mental health, as a functional diagnosis.
- Provide specific training/guidance around what types of information pediatricians/MDs want and/or need from behavioral health providers and what types of information behavioral health providers need/want from MDs.
 - o The Task Force puts special importance on improving information sharing when a child is getting psychotropic meds prescribed by a BH provider, but the pediatrician is providing ongoing monitoring of the medication. Sharing best practices in this area would be especially useful.

Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

- Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages. This is especially true for behavioral health care where there is often an evolutionary process in settling on the correct diagnosis.
- Providers need training on how to explain the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.). Best practices including scripts and checklists should be disseminated widely.
- Strategies that encourage information sharing such as having sharing as the default with families signing only if they want to "opt out" need important safe guards that ensure enough context is shared that the families know what they are agreeing to.
- Special issues of confidentiality must be considered for adolescents, including how and when to transition from having their parent/proxy as the signer and also addressing the sensitivity in putting a diagnosis or confidential services delivered to a teen into the medical record to avoid being seen by the teen's family. Suggestions for how to document that, so that payers can have a record, and other providers can become aware, without risking release of confidential information would be helpful.

- See for example issues raised in the MCPAP/DPH BSAS alcohol and substance abuse screening toolkit www.mcpap.com/pdf/CRAFFT%20Screening%20Tool.pdf, p. 15-16.
- Peer networks offer important opportunities to support youth in understanding privacy protections that exist in different settings and promote **strategic sharing** that identifies what is appropriate information to share

Sharing behavioral health information with families/youth can improve accuracy and patient safety.

- Adolescents and families often do not see a lot of the information that is in their behavioral health records as well as information that is shared among staff at the primary care provider's office and with the medical care team. Having providers consistently share information with the youth/family should be viewed as a fundamental component to protecting patient safety and preventing sharing of incorrect information.
- Share best practices where youth have been empowered to review their medical records.

Look at privacy as a whole, not just within electronic health records.

- New modes of communication (remote servers, email, the cloud...) offer important opportunities to improve communication among disparate members of a child's care team. Strategies for promoting effective use of these technologies should be part of the recommendations.
- Still, it is important to recognize that electronic medical records make it so easy to share without thinking, so suggestions for how to ensure that only minimally necessary information is generated from an EHR, that still allows providers to take advantage of the ease of electronically generating records/forms, are crucial.

References available on request.

Please contact Val Konar, staff lead for the MA Child Health Quality Coalition Communication and Confidentiality Task Force: valerie.konar@state.ma.us

ATTACHMENT C: SOURCES

Presentations to the Advisory Council

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Richard C. Antonelli, MD, MS, Boston Children's Hospital, *Achieving Accountability for Optimal Outcomes: Care Coordination as a Driver to Integration of Behavioral and Medical Care Delivery*, February 4, 2013

Glenn Focht, MD and Marilyn Manion, MD, Pediatric Primary Care Organization at Children's (PPOC), *Challenges of Behavioral Healthcare Delivery in a Pediatric Primary Care Network and Discussion of a New Integrated Model*, March 4, 2013

Reports and Data on Children's Behavioral Health

Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999

NIMH, *Mental Illness Exacts Heavy Toll, Beginning in Youth*, June 2005

NIMH. *Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services*, January 04, 2011

Care Coordination and Integration

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Massachusetts Child Psychiatry Access Program (MCPAP)

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Workforce Development

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org/cs/root/physicians_and_allied_professionals/training_toolkit

National Federation of Families for Children's Mental Health

<http://certification.ffcmh.org/resources>

Innovative and Evidence-Based Programs

Children's Behavioral Health Initiative: <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/>

Patient Centered Medical Home Initiative: <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/>

Child Health Quality Coalition: <http://www.mhqp.org/collaboration/chqc.asp?nav=063700>

Family Talk: <http://fampod.org>

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Physician Work Group Recommendations
to the
Cost Containment Behavioral Health Task Force
(Chapter 224, Section 275)

The Physician Work Group includes physicians from internal medicine, pediatrics, child and adult psychiatry who are invested in our healthcare delivery system and are actively engaged in clinical work. We met twice to discuss and prioritize recommendations for consideration by the Behavioral Health Task Force in planning its recommendations to the State Legislature in fulfillment of Section 275. The Physician Work Group applauds the principles outlined by the Behavioral Health Integration Task Force and offers the following to optimize the likelihood of success.

1. **The definition of behavioral health integration must include the coordination of care across all areas of medical and mental health (including substance abuse).** A structural framework which would support this redesign is the Chronic Care Model. It is critical that an accountability framework be articulated and adopted, since success will only occur as a result of full engagement at all levels of the community. Specifically, this requires leadership at the highest levels (Governor, Legislature, State Agencies, and the administrative leaders throughout the healthcare delivery system) to embrace Behavioral Health Integration as fundamental to creating new models of healthcare delivery that will be sustainable and cost containing. Without this level of understanding, buy-in, and championship, Massachusetts will not be able to implement an integrated model of care that is accountable, cost containing, team based, and patient/family driven. *The political will must be there to lead the nation.*

We ask those in authority not only to command integration but to model its spirit by identifying and working to mitigate laws, statutes, regulations, policies, departmental divisions, payment practices, and other structural and cultural elements of the system which, though meaningful in their creation, may serve to prohibit, inhibit, obstruct, and/or disincentivize the very processes necessary for care integration.

2. Management of payment for behavioral health services should promote coordinated and integrated care that prevents fragmentation and redundancy. **The concept of Behavioral Health Carve-Out models is antithetical to integration.**
3. **Parity and equity of payment must support team based care.** There needs to be an equitable distribution of finances (including cost savings and bonus/incentives) across the entire medical care team to value and include currently unfunded services such as care coordinators, screening, recovery supports and community/family/peer involvement to name some. Fee-for-service arrangements work against parity for all the mental health provider types within the team. A fee-for-service approach that pays each

practitioner individually will never lead to team based care. The loss of “carve outs” must not endanger the robust participation of mental health providers on the team as integration requires.

4. **Initial implementation should be incremental and target specific patient populations.** In order to change the system, we must start with success. To do this, we encourage adopting a process that is incremental, adequately funded, and targets specific populations with significant opportunity for cost savings. These would include high utilizing populations as well as large populations with moderate utilization, but whose care is amenable to collaborative care models between primary and behavioral health care providers. Examples are already underway in Massachusetts and include the Duals Demonstration (Medicare and Medicaid insured population), Primary Care Payment Reform (targeting chronic medical conditions co-occurring with behavioral health conditions) and Health Homes (targeting the Severe and Persistently Mentally Ill). These targeted programs will require new infrastructure, new shared accountabilities, and implementation of measures to drive transformation. We aim to show cost savings early on, with the expectation that success will encourage leaders and care delivery systems to adopt these new models. Adequate funding alongside movement away from fee-for-service within the integration models is crucial for leading the way as a Commonwealth and as a Nation.

5. **In the initial years of implementation of new models, both process and outcome measures should be used** until we learn from our experience with these new models and can develop appropriate outcome measures. We need to understand how these new models are impacting patients and families so they can be appropriately adapted as needed. The state of evidence for coordinated care and integrated care (especially in children) is in the early phases of development.

6. **Care coordination will be essential to achieve high quality care integration.** Currently, robust measures of care coordination (the activities in the “space between” visits and providers) are insufficiently tracked. We recognize the many “Saints in the System” who have historically provided these kinds of services without quantifying their time and its cost. We therefore promote the notion that a framework of care coordination that identifies the elements, activities, and its measures be adopted across all systems of care and adequately funded.

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XI. Appendix C. Description of Clinical Models of Behavioral Health Integration

To describe the different clinical models of behavioral health integration, this briefing book summarizes the most concise and comprehensive review of integration models presented in a publication written by the Milbank Memorial Fund. “Evolving Models of Behavioral Health Integration in Primary Care,” outlines eight different models ranging from a simple approach of increasing communication between providers to a fully integrated individualized care plan that spans the continuum of services.¹²⁵ While these models are described in a discrete way, primary care practices and outpatient behavioral health settings can adopt more than one model simultaneously or adopt a few key components of any one model to fit their needs. The models of behavioral health integration are described below.

Improving collaboration between separate providers¹²⁶

Improving collaboration between separate providers is the act of increasing communication within the existing structure of health care delivery. It is the model that requires the least amount of change and may sometimes be the only viable model given financial and external constraints. Some examples of improved collaboration include the use of a care manager for care coordination for a specific chronic condition like depression, telephonic consultation between behavioral health providers (BHPs) and PCPs, and increased use of other ways of sharing clinical information. There is no evidence to support the effectiveness of this model, but it can be a good first step toward further integration.

Medical-provided behavioral health care¹²⁷

Medical-provided behavioral health care is the use of evidence-based clinical principles by medical physicians to care for the behavioral needs of a patient with minimal, if any, collaboration with a BHP. For example, a PCP can use a variety of screening tools and techniques that have been effective in treating some behavioral health conditions. The tools include the Patient Health Questionnaire (PHQ-9) and the Screening, Brief Intervention, Referral and Treatment (SBIRT) programs implemented by SAMHSA and the Office of National Drug Control Policy (ONDCP).

In some instances, this model can also be combined with the improved collaboration model to give primary care physicians an opportunity to consult with a BHP for clinical guidance.

¹²⁵ C. Collins. *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Milbank Memorial Fund. 2010.

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

While evidence supports the use of screening tools and brief intervention counseling, the barriers to implementation include lack of time during an appointment and availability of training for the PCPs. Use of this model may highlight the lack of the behavioral health care support elsewhere in a community. First, the available resources in the community may not be able to support the increased identification of patients with higher behavioral healthcare needs. Second, PCPs need to provide more behavioral health care when there is inadequate access to behavioral health services in a community.

*Co-location*¹²⁸

PCPs and BHPs who are co-located, are able to provide comprehensive medical and behavioral health care to patients under one roof. This model builds upon the first two by combining office space and in some cases, staff. Co-location does not include the integration of the medical record, but can increase information sharing capabilities. Patients with low-level behavioral health needs may prefer this model of integration because it lessens the stigma associated with “therapy.” Certain benefits of this model include the physical presence of BHPs with PCPs which allows for a forum conducive to increased training and education of PCPs, perhaps influencing diagnosis and treatment for patients.

*Chronic care model*¹²⁹

The Chronic Care Model developed by Ed Wagner¹³⁰ serves as the basis for this integration model. It is a model of care management that is practiced within the primary care setting to address populations of patients with chronic illnesses. Familiar to many PCMH initiatives, this integration model requires early identification (through the use of evidence-based screening tools), intensive care management, the use of a patient registry and evidence-based clinical guidelines in the treatment of care. This model enhances all of the models already described above. There are a variety of well-funded and well-conducted research studies that show positive clinical outcomes and reduced costs. In addition, specific programs built off of this model (see Depression Care in Minnesota in Section C of this Chapter) have proven to be successful. This model works effectively when used in combination with more integrated approaches (described below.)

*Reverse co-location*¹³¹

As its name suggests, reverse co-location is similar to the co-location model with the exception that a medical health professional (e.g., MD, CRNP) provides care within the behavioral health care setting. This model can be effective when treating patients with serious behavioral health

¹²⁸ C. Collins. *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Milbank Memorial Fund. 2010.

¹²⁹ Ibid.

¹³⁰ Bodenheimer T, Wagner E, Grumbach K. “Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2,” *JAMA*, October 16, 2002, 288:15, 1909-1914.

¹³¹ Ibid.

needs and those whose mental health needs priority attention. Reverse co-location often occurs in more intensive mental health settings like day treatment or rehabilitation programs, but is also found in some community mental health center (CMHC) settings. Collins et al. reference evidence that this model has reduced costs through the reduction in emergency room visits.

*Unified primary care and behavioral health*¹³²

One of the most fully integrated models, unified primary care and behavioral health, combines the benefits of co-location with an integrated medical record, treatment plan and financing. This model is sometimes used in federally qualified health centers (FQHCs) where patients can expect to receive full physical and mental health care in one setting. Providing psychiatric services as part of a primary care visit has shown to improve health status and reduce ED visits.¹³³

Achieving this level of integration is a complex transition to manage with many barriers. Some insurance carriers will reimburse providers less if behavioral health and physical health care are provided in one setting. If insurance carriers do provide reimbursement, what services are covered will vary from one to the next – some may allow same-day billing, others may not. In the Medicaid program, pediatric and adult patients are typically reimbursed under different payment methodologies making it difficult for a family practice office to achieve this level of integration.

*Primary care behavioral health*¹³⁴

Primary care behavioral health is the combination of three models – co-location, disease management and unified primary care and behavioral health. Users of this model provide behavioral health care in a more seamless way than in any of the models discussed thus far. BHPs are fully integrated into the care of a patient and are often sharing clinical management responsibilities with the PCP. A common approach to care coordination is through the “warm hand-off” - where a patient is introduced to a BHP by the physician within one visit. The population-based approach allows for all patients to receive brief interventions and provides needed care real-time.¹³⁵ Another highlight of this model, according to Hunter and Goodie, is the unique goal to transfer behavioral health skills to a primary care physician through co-management and repeated consultative interactions.¹³⁶ As expected, this model requires system-level and practitioner-level change. It is no longer just the provision of behavioral health services in the primary care setting; it is a seamless collaborative approach to patient care.

¹³² C. Collins. *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Milbank Memorial Fund. 2010.

¹³³ Ibid.

¹³⁴ Ibid.

¹³⁵ C. L. Hunter and J. L. Goodie. Operational and Clinical Components for Integrated-Collaborative Behavioral Healthcare in the Patient-Centered Medical Home. *Families, Systems & Health*. Vol. 28, No. 4 308-321. 2010.

¹³⁶ Ibid.

*Collaborative system of care*¹³⁷

The collaborative system of care model is not necessarily a fully-integrated approach. It is the use of an individualized care plan that spans the continuum of services (including health-critical community supports like housing). It is often used for patients with high behavioral health care needs and can exist outside of the primary care setting. The evidence for this model is mixed and according to Collins et al. the findings may be due to the highly varied nature of implementation of this model.

Select examples of clinical models of integration in Massachusetts

Massachusetts Patient Centered Medical Home Initiative (MA PCMHI)

The MA PCMHI is a state-wide, multi-payer, three-year medical home demonstration project sponsored by the Executive Office of Health and Human Services involving 46 primary care practices. Nearly 200,000 members are included, the majority of whom are MassHealth recipients. The Patient-Centered Medical Home model is designed to promote comprehensive, coordinated, patient-centered care delivered by teams of primary care clinicians.¹³⁸ The foundation of many medical homes is the **disease management** clinical model. In addition, to disease management, enhanced behavioral health integration is an essential feature of a patient-centered medical home.

In order to assist practices achieve behavioral health integration, MA PCMHI created a Behavioral Health Work Group (Work Group). The Work Group created a flexible approach to behavioral health integration achievable by all practices within the initiative, **regardless of which clinical model used**. The Work Group developed a set of key characteristics (“Elements of Integration”) that describe an essential integration activity to support the behavioral health needs of patients within a primary care practice.¹³⁹ The Elements of Integration are organized into five clinical domains. Included within the Elements of Integration are foundational elements that are believed to be essential to achieving behavioral health integration. Non-foundational elements advance behavioral health integration, but are typically only achievable by practices with advanced clinical integration models.

Accompanying the Elements of Integration is a toolkit of strategies to assist practices in achieving each element and a suggested approach for prioritizing the elements. (See Sub appendix A for the MA PCMHI Elements of Integration).

MassHealth Primary Care Payment Reform Program (PCPR)

¹³⁷ C. Collins. *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Milbank Memorial Fund. 2010.

¹³⁸ “Overview of PCMHI” Massachusetts Patient-Centered Medical Home Initiative” Massachusetts Executive Office of Health and Human Services <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/>. Last accessed 12-3-2012.

¹³⁹ MA Patient Centered Medical Home Behavioral Health Work Group, Dr. Alexander Blount, Mountainview Consulting.

The goal of MassHealth's Comprehensive Primary Care Payment Reform strategy is to improve access, patient experience, quality, and efficiency through care management and coordination, and integration of behavioral health primary care.¹⁴⁰ The program achieves its vision through the adopting a payment mechanism for care provided within a fully-integrated patient-centered medical home. In addition to the organizing principles of the patient-centered medical home, the PCPR adopted the Massachusetts PCMHI-specific approach to behavioral health integration by further refining the Elements of Integration (mentioned above) and expecting that participants will have the functional capacity to provide, at a minimum the foundational elements of integration. (See Sub appendix B for PCPR revised Elements of Integration).

Massachusetts Child Psychiatric Access Project (MCPAP)

MCPAP is a system of regional children's mental health consultation teams designed to help primary care providers meet the needs of children with psychiatric problems.¹⁴¹ Funded through the Department of Mental Health, MCPAP assists providers in treating children by providing telephone access to child psychiatrists, clinical nurse specialists, licensed therapists and care coordinators. Primary care clinicians may use MCPAP to obtain information necessary to treat children with behavioral health needs effectively or receive advice on appropriate referrals. MCPAP is an effective approach to **improving collaboration between separate providers** and assisting in achieving **medical-provided behavioral health care**.

Massachusetts Dual-Eligibles Capitation Demonstration Program

Massachusetts is the first of twenty-six states to enter into a joint Medicare and Medicaid financial alignment demonstration to manage the health care services of individuals between 21 and 64 who are eligible for both Medicare and Medicaid services. (For more information on the financial model, see page 14). Integrated behavioral health services are a chief component of the program, with health plans required to provide not only integrated behavioral health and primary care, but also behavioral health through community-based and long term support services. Each health plan is expected to support the foundational Elements of Integration delineated by the MA PCMHI Behavioral Health Work Group (See Appendix A). Unlike the clinical integration models previously described, this model is health plan focused. Enrollment is expected to begin in the spring of 2013.

Children's Behavioral Health Initiative (CBHI)

CBHI is a program of the Executive Office of Health and Human Services that requires primary care providers to administer standardized behavioral health screenings at well child visits, mental health clinicians to use a standardized behavioral health assessment tool, and provides

¹⁴⁰ MassHealth Comprehensive Primary Care Payment Reform Clinical Delivery Model. Unpublished.

¹⁴¹ About MCPAP. <http://www.mcpap.com/about.asp> Last accessed 12-3-2012.

new or enhanced home and community-based behavioral health services.¹⁴² CBHI has made significant investments in improving the care provided by behavioral health providers and in developing an integrated system of state-funded behavioral health services for children, youth and their families.¹⁴³ In addition, CBHI provides a potential platform for integrating primary care so that providers would have some level of **medical-provided behavioral health care**.

Wellness Center at Community Health Link

The Wellness Center at Community Health Link is an outpatient behavioral health clinic with an integrated primary care clinic. The primary care clinic focuses specifically on the medical needs of patients with serious and persistent mental illness. This model, commonly referred to as **reverse co-location**, typically serves the most complex (medically and behaviorally) patients who are frequent utilizers of health care.

Select examples of clinical models of integration in other states

Missouri Health Homes

Missouri has implemented “Health Homes,” which are “person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community based services and supports.”¹⁴⁴ Health Homes are similar in concept to Patient Centered Medical Homes, with the exception that Health Homes focus upon the specific needs of low-income individuals with complex and chronic needs. Health Homes provide enhanced complex care management, care coordination, patient and family support and referral to community and long term support services.

Missouri chose to implement Health Homes as a means to reduce hospitalization and emergency department visits, enhance the behavioral health consultation available at primary care centers and enhance the State’s ability to provide transitional care between institutions and the community.¹⁴⁵

Depression Care in Minnesota (DIAMOND)

The DIAMOND¹⁴⁶ project is a depression chronic care management program focused on the primary care delivery system. DIAMOND offers specific payment for the use of evidence-based depression care management, rooted in the collaborative care model. The model includes the standard and consistent use of evidence-based depression screening tools for assessment and management of depression, the follow-up and tracking of patients with depression through

¹⁴² Children’s Behavioral Health Initiative. <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-initiative-overview.html> Last accessed 12-3-2012.

¹⁴³ Ibid.

¹⁴⁴ “Medicaid’s New ‘Health Home’ Option” January 2011. Kaiser Family Foundation <http://www.kff.org/medicaid/upload/8136.pdf>

¹⁴⁵ Joe Parks. “Health Homes in Missouri” January 2012. Unpublished presentation.

¹⁴⁶ DIAMOND stands for “Depression Improvement Across Minnesota Offering a New Direction”

the use of a registry, use of evidence-based guidelines for treatment, relapse prevention, education and psychiatric consultation.¹⁴⁷

The model has been successful and has shown improvements in the percentage of patients assessed with an evidence-based screener at the time of depression diagnosis and the percent of patients seen for follow-up at three and six months. In addition, studies have shown that over 40 percent of patients who experience the DIAMOND model are in remission within 6 months and another 10 percent have had a drastic reduction in symptoms.

Iowa's Integrated Health Homes

Iowa contracts with a statewide Medicaid BHO to deliver behavioral health needs to the seriously mentally ill. Included within the capitation to the Medicaid BHO is 2.5 percent dedicated to funding initiatives to improve health care. One such initiative is the Integrated Health Home program, a **reverse co-location** concept that brings primary care to the behavioral health care site. With the behavioral health site as the point of entry, patients with serious and persistent mental illness are able to receive integrated treatment with the behavioral health provider leading the treatment team.¹⁴⁸ Behavioral health services are currently paid for under the Medicaid BHO capitation rate, while the primary care services are paid on a fee-for-service basis.¹⁴⁹

¹⁴⁷ Oftedahl, G et al. "DIAMOND Initiative Depression Improvement Across Minnesota Offering a New Direction" Presentation to ICSI Colloquium May 17, 2007.

¹⁴⁸ "Magellan launches integrated health home in collaboration with state of Iowa to improve access to care, control costs." Magellan health services. <http://ir.magellanhealth.com/releasedetail.cfm?ReleaseID=594039> Last accessed 12-6-2012

¹⁴⁹ Hamblin A et al. "State Options for Integrating Physical and Behavioral Health Care." *Integrated Care Resource Center* October 2011.

XII. Appendix D. The National Council’s Four Quadrant Model

The National Council’s Four Quadrant Model

Behavioral Health (MH/SA) Risk/Complexity →	Quadrant II BH↑ PH↓	Quadrant IV BH↑ PH↑
	<ul style="list-style-type: none"> Behavioral health clinician / case manager w/ responsibility for coordination w/ PCP PCP (with standard screening tools and guidelines) Outstationed medical nurse practitioner / physician at behavioral health site Specialty behavioral health Residential behavioral health Crisis / ED Behavioral health inpatient Other community supports 	<ul style="list-style-type: none"> PCP (with standard screening tools and guidelines) Outstationed medical nurse practitioner / physician at behavioral health site Nurse care manager at behavioral health site Behavioral health clinician / case manager External care manager Specialty medical / surgical Specialty behavioral health Residential behavioral health Crisis / ED Behavioral health and medical/surgical inpatient Other community supports.
	Quadrant I BH↓ PH↓	Quadrant III BH↓ PH↑
	<ul style="list-style-type: none"> PCP (with standard screening tools and guidelines) PCP-based behavioral health consultant / care manager Psychiatric consultation 	<ul style="list-style-type: none"> PCP (with standard screening tools and guidelines) PCP-based behavioral health consultant/care manager (or in specific specialties) Specialty medical / surgical Psychiatric consultation ED Medical/surgical inpatient Nursing home / home based care Other community supports
	Physical Health Risk/Complexity →	

XIII. Appendix E. Summary of the MA PCMHI Behavioral Health Integration Toolkit

The Massachusetts Patient-Centered Medical Home Initiative (MA PCMHI) is a state-sponsored and facilitated multi-payer effort involving 46 primary care practices, representing a diversity of practice settings, geography and patient populations served. Fifty-two percent of practices are community health centers; others are academic or large and small private practices. As part of the MA PCMHI, the state launched a Behavioral Health Integration Work Group (Work Group) in April 2011 for the purpose of assisting MA PCMHI practices to overcome the system and practice-level challenges that they face when providing primary health care to patients of all ages with mental health disorders, unhealthy substance use, and/or health behavior change needs, including behavioral health and primary care integration. The Work Group is comprised of representatives of health plans, MA PCMHI practices, outpatient behavioral health providers, various state health and human service agencies, and provider faculty of the University of Massachusetts Medical School. The deliverables of the Work Group include a toolkit for behavioral health integration for the participating primary care practices and a practice self-assessment to establish baseline integration status and to monitor progress toward integration.

39 Elements of Integration

To create the self-assessment and toolkit, the Work Group researched models of integration. Using “Behavioral Health Integration Needs Assessment” authored by Mountainview Consulting and Work Group member Dr. Alexander Blount as a guide, the Work Group defined 39 unique elements of integration.

The 39 elements of integration are organized within 5 domains: (1) Relationship and Communication Practices, (2) Patient Care and Population Impact, (3) Community Integration, (4) Care Manager Practices, and (5) Clinic System Integration. Within each domain, the Work Group identified foundational elements of integration, that is, those elements of integration the Work Group felt to be primary to achieving the cornerstones of behavioral health integration within a PCMH practice.

The elements of integration were then translated into a practice self-assessment survey by assigning a scale of integration for each element. Typically, the scale ranged from “rarely” achieving the particular element of integration to “routinely.” The self-assessment was intended to be completed by the primary care team in conjunction with one or more behavioral

health providers within the practice at regular intervals to establish a baseline and to track individual practice progress toward integration over time.

Toolkit of Strategies

The Work Group created a toolkit of evidence-based strategies and resources designed to help practices achieve the highest level of integration for each of the 39 elements. The strategies and resources are presented as a dynamic online tool with a mixture of video, exercises, templates, web links and step-by-step instructions within each domain. After each practice prioritizes the elements of integration according to its needs, the practice can access the online toolkit for tips and strategies. The toolkit was completed in March 2013 for MA PCMHI practices and is scheduled to be made publicly available in the summer of 2013.

XIV. Appendix F. ABH / Mass League Regulatory and Reimbursement Barrier



ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE



DPH Regulations that Hinder the Integration of Behavioral Health and Primary Healthcare¹⁵⁰

November 30, 2011

Primary care settings routinely provide detection, prevention and treatment of a wide range of chronic diseases and health conditions in patients of all ages, however, services related to the prevention and treatment of mental health and substance use disorders remain the exception. Behavioral health providers similarly face obstacles in trying to address the physical healthcare needs of their clients. The result is a fragmented system of care and missed opportunities for the prevention and treatment of mental health and substance use disorders.

For a behavioral health outpatient center to provide health care by *building-in* medical services into their outpatient clinics, the provider must become credentialed, obtain hospital privileges and be part of an Independent Practice Association (IPA), which are significant obstacles for behavioral healthcare providers to overcome.

For a medical site, such as a Community Health Center, private practice or hospital to contract with a behavioral healthcare provider to co-locate behavioral health services at their facility, there are restrictions around contracting and limitations regarding the *outreach site* which permits only a maximum of 20 hours of service per week, with further complications related to record storage and requiring the behavioral health clinic to be established as a satellite clinic, which is a complicated and expensive undertaking.

The Association for Behavioral Healthcare (ABH) and the Massachusetts League of Community Health Centers (MLCHC) joined forces to identify and develop some of the steps that must be taken to promote the integration of behavioral health and primary healthcare, with the overarching goal of improving client outcomes. Our first initiative has been to identify the Department of Public Health's regulatory roadblocks to integration, and to work with the state to address them.

Some specific DPH regulatory barriers to the integration of care are outlined as follows:

¹⁵⁰ CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects, Center for Health Policy and Research, UMASS Medical School, January, 2008

1. **Staffing:** There are conflicting licensure regulations regarding the type of staff that can be employed for different facility types, which impedes integration. For example, see 105 CMR 140.310 to 330: General Requirements for all Clinics/Staff, 105 CMR 140.530 Subpart E Mental Health Services/Staffing, and 105 CMR 140.800 Subpart H for Substance Abuse Services which refers licensees to DPH/BSAS regulations at 105 CMR 164 *Licensure of Substance Abuse Treatment Programs*, and its staffing requirements.
2. **Architectural Drawings:** A behavioral health organization trying to establish a health center is required by DHCQ to find the location's original architectural drawings, which often are decades old and cannot be located.
3. **Out-of- Date Requirements:** DHCQ has many out-dated requirements for establishing a primary health clinic, such as requiring a *flushrim sink* (at a cost of \$6,000), which is appropriate for collecting tissue samples; but that practice is no longer utilized by even primary health care practices. All such requirements need to be reviewed.
4. **Subcontracting:** DHCQ clinic licensing regulations do not allow community health centers to subcontract with a behavioral health provider to deliver behavioral health services at the community health center.
5. **Record Keeping and Information Sharing:** DHCQ licensing requires that clients have separate physical health and behavioral health records. DPH/BSAS regulations regarding records requirements and information sharing limit the capacity of providers to share information that is needed for care coordination. This is one barrier which needs considerable thought.
6. **Paperwork Disincentives to Brief Interventions:** BSAS licensing paperwork requirements are extensive and may be a disincentive to the brief assessment and treatment that are necessary to support collaborative care with behavioral healthcare. For example, if a physician sends a patient to a behavioral health provider for a *lifestyle* session, the behavioral health provider must open a case and complete about 40 pages of documentation (e.g., intake assessment, evaluation form, treatment plan, release of information forms, and substance and nicotine and TB assessment) in order to work with that client.
7. **Shared Waiting Rooms:** Regulations prohibit behavioral health and primary care services from sharing waiting rooms. Although this regulation was an effort to minimize stigma for behavioral health clients, it has actually resulted in the opposite response by increasing stigmatization through separate waiting rooms. Obtaining a waiver from this requirement can take a year or more, if granted at all.
8. **Architectural Limitations:** The architectural requirements in 105 CMR 140.200 are difficult for many behavioral health clinics to comply with. For example, drug storage and pharmacy requirements, different types of lab services and maintenance, additional bathrooms/sanitation, drug shelf life, disinfection and sterilization, etc. Behavioral health providers may not have the space or plumbing available to make such changes, and retrofitting an existing space is extremely costly.

RECOMMENDATIONS

1. **Staffing:** Coordinate regulations regarding Staffing requirements at 105 CMR 140.310 to 330: General Requirements for all Clinics/Staff, 105 CMR 140.530 Subpart E Mental Health Services/Staffing, and 105 CMR 140.800 Subpart H for Substance Abuse Services which

refers licensees to DPH/BSAS regulations at 105 CMR 164 *Licensure of Substance Abuse Treatment Programs*, and its staffing requirements.

2. **Record Keeping:** Modify medical record requirements mandated under DPH licensing for behavioral health services provided in a primary care setting. We recommend that amending the DPH regulations regarding the separation of the patient behavioral health and physical health record be prioritized.
3. **Deemed Status:** Community health centers, primary care and behavioral health care facilities are governed by different licenses and state and federal authorities and subject to duplicative licensing processes, record reviews and site visits, making a strong case for granting *Deemed Status* to all organizations which have obtained national accreditation or licensure/certification.
4. **Architectural Barriers:** Allow flexibility and/or grant waivers from some of the more onerous architectural requirements for behavioral health clinics, to promote the integration of primary health care.
5. **Demonstration Projects:** Grant waivers to a select number of demonstration projects to allow DPH and/or MassHealth to determine costs and benefits of new codes to determine if a statewide policy is financially feasible. Other potential waivers for consideration include:
 - DPH waiver(s) to allow CHCs to subcontract with Community Mental Health Centers and Substance Abuse Outpatient Clinics to provide behavioral health services at the CHC.
 - Modification of the CMHC medical record requirements mandated under DPH licensing for behavioral health services provided in a primary care setting.
 - Grant DPH waivers for licensure requirements regarding space and integrated care practices.

ABH and the MLCHC recommend that DPH establish a task force in the near future to that can immediately undertake a formal review and discussion of these barriers, and the development of short and long-term remedies. We look forward to working with DPH to address these barriers to the integration of care.



ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE



MassHealth Regulations that Hinder the Integration of Behavioral Health and Primary Healthcare¹⁵¹

July 3, 2012

Primary care settings routinely provide detection, prevention and treatment of a wide range of chronic diseases and health conditions in patients of all ages. However, services related to the prevention and treatment of mental health and substance use disorders remain the exception. Behavioral health providers similarly face obstacles in trying to address the physical healthcare needs of their clients. The result is a fragmented system of care and missed opportunities for the prevention and treatment of mental health and substance use disorders.

For a behavioral health outpatient center to provide health care by *building-in* medical services into its outpatient clinics, the provider must become credentialed, obtain hospital privileges and be part of an Independent Practice Association (IPA), which are significant obstacles for behavioral healthcare providers to overcome.

For a medical site, such as a community health center, private practice or hospital to contract with a behavioral healthcare provider to co-locate behavioral health services at its facility, there are restrictions around contracting and limitations regarding the *outreach site* which permits only a maximum of 20 hours of service per week, with further complications related to record storage and requiring the behavioral health clinic to be established as a satellite clinic, which is a complicated and expensive undertaking.

The Association for Behavioral Healthcare (ABH) and the Massachusetts League of Community Health Centers (MLCHC) joined forces to identify and develop some of the steps that must be taken to promote the integration of behavioral health and primary healthcare, with the overarching goal of improving client outcomes. Our initiative on this front has been to identify the Department of Public

¹⁵¹ CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects, Center for Health Policy and Research, UMASS Medical School, January, 2008

Health and MassHealth regulatory roadblocks to integration, and to work with the state to address them.

Some specific MassHealth regulatory barriers to the integration of primary and behavioral health care are as follows:

1. MassHealth has not yet activated billing codes for brief assessment and intervention services, using the federally-approved Health and Behavior codes.
2. Direct billing and global capitation rates do not cover the array of tasks that are needed to provide collaborative care, such as making referrals, informal communication, care and service coordination. The Community Health Center (CHC) global capitation rate does not take into consideration the high level of social needs of behavioral health patients. There are no MassHealth billing codes to support integration and collaboration, such as a care management case rate or a case rate to bill for clients with multiple social, medical, and/or behavioral health needs.
3. Funding silos, categorical funding, and a multitude of differing billing and credentialing requirements for different payers are significant barriers to collaborative care. There is a lack of clarity about what provider types can bill for what services in various settings for individuals enrolled in the FFS, MCO and PCC plans.
4. Primary care access to psychiatric consultation is limited by the rate of reimbursement, and by no reimbursement mechanism when a patient is uninsured. The current rate does not cover the time it takes to open a case.
5. Innovative consultation methods such as videoconferencing, telepsychiatry and telehealth are not reimbursable by MassHealth.
6. Primary care providers do not have the time to sort out a patient's insurance status in order to make a referral to a Community Support Program (CSP). The MassHealth MCOs have different authorization processes for CSPs and provide different amounts of CSP services. Uninsured patients cannot receive CSP services because CSP services are not eligible for UCP reimbursement.
7. There are no reimbursement codes for processes that support *bi-directional* physician-clinician interaction, such as clinical team meetings and CHC physician-Community Mental Health Center (CMHC) clinician trainings.
8. Funding and technical assistance is needed by integration projects to develop and implement the processes needed to support joint collaboration.
9. CHCs and CMHCs need a reimbursement mechanism for providing outpatient behavioral health services for uninsured community health center patients. Currently, CMHCs cannot be reimbursed from the Safety Net for services provided to uninsured patients; and CHCs are required to serve the uninsured, who represent a substantial proportion of their patient population.

10. CMHCs cannot bill for a physician or Nurse Practitioner placed at a licensed mental health clinic to provide primary healthcare services.
11. Same-day service billing restrictions are a big barrier to the delivery of coordinated primary and behavioral healthcare.

Recommendations:

To achieve the goal of enhancing CHC and CMHC provider-capacity to deliver collaborative care will require significant systems change to align policies, regulations, and reimbursement mechanisms. MassHealth must provide the leadership in elevating the need for collaborative care that is safe, timely, patient-centered, efficient, effective, and equitable. Leadership, visibility and commitment of resources are required to address the myriad of issues that serve as barriers to the delivery of integrated care. Specific recommendations include:

1. MassHealth should activate the federally-approved Health and Behavior codes and Substance Abuse Assessment and Treatment codes to create reimbursement streams to support the co-location of all levels of behavioral health disciplines in CHCs, and primary healthcare disciplines in CMHCs. Such codes are billable in a number of states and by some commercial insurers in selected states. The cost to MassHealth to activate these codes is unknown. Granting waivers to a select number of projects would allow MassHealth to determine costs and benefits of these new codes, and determine if such a statewide policy is financially feasible.
2. Collect and analyze billing requirements across the FFS System, MCO, and PCC Plans to address the question, “Who (primary care, mental health, addiction treatment staff) – at various clinical levels – (MD, PhD, PA, RN, LICSW, LCSW, etc) can be paid, how much, by whom, under which benefits, in which settings, and for how long.”
3. Program development and integration requires funds and technical assistance to support planning, meeting, technical assistance, project management, and training. Currently, there is no revenue stream to fund these activities over time.
4. Explore the granting of waivers to eliminate barriers and evaluate the sustainability of collaborative care models. Granting waivers to a select number of projects would allow MassHealth to determine costs and benefits of new codes to determine if such models are financially feasible.
5. Establish a funding mechanism for Suboxone® and Vivitrol at CHCs and CMHC’s, including both billable and non-billable services.
6. Review MassHealth same-day service billing restrictions, and remove those that serve as barriers to the delivery of quality care in a coordinated primary and behavioral healthcare system.

ABH and the MLCHC recommend that MassHealth establish a task force in the near future that can immediately undertake a formal review and discussion of regulatory and rate barriers, and the development of short and long-term remedies. We look forward to working with MassHealth to address these barriers to the integration of community-based primary and behavioral health care.

XV. Sub Appendix A. MA PCMHI Elements of Integration

Massachusetts Patient Centered Medical Home Behavioral Health Work Group Elements of Integration

The following are the Elements of Integration that signify integration of primary care and behavioral health in each of five practice areas or domains of care delivery. These elements were defined by the Massachusetts Patient-Centered Medical Home Initiative (PCMHI) Behavioral Health Work Group in consultation with Mountainview Consulting and Work Group member Dr. Alexander Blount, as essential for a primary care provider to effectively integrate behavioral health services.

I. Relationship and Communication Practices Domain

***Triaged Access at Emergent, Urgent and Routine Times**

The behavioral health service providers have a reliable positive working relationship and regular communication exchange with primary care providers.

***Smooth Hand-off**

PCPs routinely discuss patient care issues with behavioral health service providers prior to and after same-day hand-offs or prior to a scheduled initial visit.

***Sharing Expertise**

PCPs are comfortable requesting advice from behavioral health service providers about intervening with patients who present with behavioral health issues and medical issues.

***Training Activities**

Behavioral health service providers also provide periodic training and education for medical staff on behavioral health topics (e.g., at a provider meeting, through a monthly newsletter or a lunch time training on a topic of interest to PCPs).

***Program Leadership**

My practice has a defined steering group and medical champion for the behavioral health integration activities.

Team Membership

Behavioral health service providers are considered part of the care team.

II. Patient Care and Population Impact Domain

***Routine Screening and Referral for Adult Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with a standardized tool for both depression and alcohol.

***Routine Screening and Referral for Adult Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with standardized tools for PTSD, anxiety, drug abuse, domestic violence, and tobacco.

***Routine Screening and Referral for Pediatric / Adolescent Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with MassHealth approved screening tools for pediatric conditions and meet the CBHI screening requirements.

***Behavioral Health Skills Used by the Whole Primary Care Team**

PCPs and other members of the primary care team have been trained in patient activation and health behavior change methodologies.

***Behavioral Health Skills Used by the Whole Primary Care Team**

PCPs and other members of the primary care team deliver evidence-based interventions in consultation with behavioral health service providers.

Integrated Clinical Pathways

The practice targets two or more specific patient populations for the development of evidence-based behavioral health services, registries and care management (e.g., patients with chronic disease, depression, etc.)

Family Focus Care - Pediatrics

The practice collaborates with parents, youth and key caretakers to develop a care plan.

Supporting Health Behavior Change

Patients are referred to behavioral health service providers for support with lifestyle changes and management of medical problems. Patients considered for this referral include patients exhibiting specific medical markers of illness or complexity (e.g., obesity, diabetes, chronic

illness, chronic pain, sleep, heart disease, and other medical problems), patients reporting unhealthy lifestyle behaviors and patients who have somatic complaints that have a lifestyle or stress component.

III. Community Integration Domain

***Self-Help Referral Connections**

The practice has available and regularly uses referral information for self-help groups, and offers books, pamphlets and websites that foster patient self-help.

***Community Group and Resources Connections**

The practice provides linkages that facilitate the connection of patients with community resources such as gyms, churches, housing and food support.

***Specialty Mental Health and Substance Abuse Referral Connections**

The practice has referral and information-sharing protocols with an array of mental health and substance abuse specialty services.

Engagement with Specialty Mental Health and Substance Use Disorder Agencies

The practice has regular problem-solving meetings with high use agencies like the local CMHC.

Peer or Patient Participation in the Administration of the Practice

The practice has patients or consumers actively involved in quality improvement efforts.

Peer or Patient Participation in Services of the Patient

The practice has patients or peers actively involved in mentoring or health coaching for other patients and / or their family members (e.g., community health workers, patient volunteers, family members, peer educators, patient navigators, support groups).

Practice Offers Behavioral Education Programs

The practice offers group behavior-educational programs (e.g., parent training, healthy living, group medical visits).

IV. Care Management Practices Domain

***Coordination of an Integrated Treatment Plan**

Integrated treatment plans (plans that include medical and behavioral health goals) are effectively coordinated by the clinical care manager.

***Use of Behavioral Health Skills**

Behavioral health skills (e.g., patient activation) are used by the clinical care manager when working with patients.

***Use of Community Resources**

The clinical care manager is aware of behavioral health-focused community resources and regularly utilizes them (e.g., by referring patients to them).

V. Clinic System Integration Domain

***Schedule Accessibility**

The practice can facilitate the scheduling of a behavioral health visit for a patient at the time of a patient visit.

***Leaders are committed to integrated care**

Practice leadership understands the value of the behavioral health service to patients and is committed to maintaining it.

***Non-clinical staff (e.g., registration, billing, management)**

Understand the value of the behavioral health service to patients and are committed to maintaining it.

***Program Staffing**

PCPs find that the practice's behavioral health provider staffing and / or referral opportunities provide sufficient behavioral health services.

***Chart Note Integration**

The behavioral health service provider chart notes are placed in the same location as PCP chart notes.

***Process Integration**

PCPs and individual behavioral health service providers use the same screeners and outcome instruments to follow progress.

Team Awareness of Behavioral Health Services

All members of the primary care team understand the role of the behavioral health service provider(s) and how to utilize him / her.

Shared Appointment Systems

There is one system for making both primary care and behavioral health appointments."

Same-Day Access

The practice has the ability to provide same-day behavioral health care when the need arises during a primary care visit.

Same-Day Access

The practice has the ability to provide same-day medical care when the need arises during a behavioral health care visit.

Open Scheduling

The practice has the capability to schedule behavioral health appointments electronically.

Extent of Co-location Integration

The behavioral health service providers and primary care providers are located in the same exam room area of the practice and provide service there. Please respond by indicating the highest-level of co-location from none to behavioral health service providers are in the same exam room.

Coordinated Scheduling

The practice's schedule allows for patients to be seen by the medical and behavioral health provider on the same day, in or near the same location.

Operational Support for the Behavioral Health Clinician

The practice's behavioral health service provider(s) perceives that he/she has adequate scheduling, reception, administrative and medical assistant support.

Facilities

The practice has adequate space needed to conduct on-site psycho-educational classes and group appointments.

XVI. Sub Appendix B. MassHealth PCPR Elements of Integration

Participants in the MassHealth PCPR are expected to have the functional capacity to provide the foundational elements of integration, which are **bolded and starred (*)**.

1. Relationship and Communication Practices Domain

***Triaged Access at Emergent, Urgent and Routine Times**

Patients have timely access based on need and acuity, to behavior change support, mental health, substance abuse and primary care services.

***Smooth Transitions**

Primary care providers (PCPs) and behavioral health providers (BHPs) routinely communicate about patient care issues prior to and after same-day or scheduled initial visits. Practices demonstrate a commitment to provide in-person introductions of team members.

***Team Membership**

PCPs and BHPs are part of the same care team.

Sharing Expertise

PCPs and BHPs have a frequent regular forum for teaching and learning, including holding clinical case reviews of patients with complex behavioral and medical issues.

Program Leadership

Primary care and behavioral health practice leaders collaborate on developing protocols, standards of practice and interventions to ensure successful communication and integration. Interventions may include the designation of primary care and behavioral health champions who foster communication and collaboration across the two disciplines.

2. Patient Care and Population Impact Domain

***Health Care Team Leader**

A leader of the health care team is identified based on patient preference and the patient's primary locus of care. The team leader is responsible for ensuring that team members are fulfilling their roles in support of the patient's care.

***Routine Screening and Referral for Adult Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with a standardized tool for depression, anxiety, substance use, intimate partner violence, suicide risk and symptoms of trauma. Screening also includes bio-psychosocial and quality of life assessments.

***Routine Screening and Referral for Pediatric/Adolescent Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with MassHealth approved screening tools for pediatric conditions and meet the Children's Behavioral Health Initiative (CBHI) screening requirements. Screening also includes bio-psychosocial and quality of life assessments.

***BHPs Role in Monitoring Patients' Physical Condition**

As members of the care team, BHPs routinely play a role in monitoring patients' physical condition on behalf of the team. This might include asking about and monitoring for adverse effects of prescribed medications and new physical symptoms that have not been reported to the team, or addressing patients' understanding of their diagnoses and treatments.

***Behavioral Health Skills Used by the Whole Primary Care Team**

PCPs and other members of the primary care team routinely screen for common behavioral health conditions as above and have been trained in skills to promote positive behavioral health change. Skills include motivational interviewing, relapse prevention planning, and basic knowledge of behavioral health referral sites to enhance delivery of evidence-based interventions, in consultation with BHPs.

***Family Focused Care**

The practice collaborates with parents, legally authorized representatives, youth, and key care takers in pediatrics, and, in accordance with patient wishes, encourages the participation of spouses, significant others, and appropriate family members in the development and implementation of treatment plans.

***Integrated Clinical Pathways**

The practice implements evidence-based protocols or treatment pathways that include behavioral health elements in the assessment and plan, as appropriate for their patient populations.

***Patient safety practices**

The practice focuses on patient safety activities by: (1) establishing protocols, (2) training their team members on safe medication practices, and (3) screening and managing patients for

suicide and public safety risks. Safe medication practices include comprehensive medication reconciliation for both physical and behavioral health medications.

***Patient Feedback and Input on Care Delivery**

The practice regularly solicits feedback from patients on its care delivery, as well as its quality improvement and patient safety activities. Feedback may be received through patient survey, the establishment of a patient/consumer advisory council, consumer participation in a practice's board of directors, patient participation in quality improvement teams and/or other modalities.

Supporting Health Behavior Change

Patients have access to BHPs to support lifestyle changes and self-management. Patients considered for this referral include those with or having risk factors for chronic medical or behavioral health conditions, patients reporting unhealthy lifestyle behaviors and patients who have somatic complaints that have a lifestyle or stress component.

3. Community Integration Domain

***Self-Help and Community Resource Connections**

The practice has organized resources to help patients identify their strengths and to understand and utilize existing community supports to complement the medical and behavioral health services provided. Community supports may include self-help groups, social service and civic agencies, spiritual supports, etc. The practice offers books, pamphlets and websites that foster patient self-help.

***Specialty Mental Health and Substance use Referral Connections**

Primary care, specialty mental health, and substance use providers have referral and information-sharing protocols, which stipulate access expectations and include plans for problem solving and coordination.

Peer/Community Support Services for Patients

The practice has group medical visits or deploys patients/family members as peers (individuals with lived experience with medical and or behavioral health conditions). Peers mentor, coach and share lived experiences with patients and their family members.

Behavioral Education Programs

The practice offers population based and/or group approaches to patient education for at least two common behavioral needs of their patient population.

4. Clinical Care Management Practices Domain

***Development, Implementation and Coordination of an Integrated Treatment Plan**

The designated Clinical Care Manager for each patient effectively coordinates integrated treatment plans, i.e. plans that include medical and behavioral health goals and which delineate roles and responsibilities of care providers.

The CCM:

- Manages the development, implementation and monitoring of a multidisciplinary care plan, created jointly by the patient/family and the health care team. The plan of care includes patient/family identified self-management goals for chronic illnesses or conditions.
- Documents the plan of care in the patient's record and updates the plan as necessary.
- Coordinates care among providers (medical, behavioral and addictions), including providers from systems of care, such as Department of Mental Health, Department of Children and Families, etc.

***Use of Behavioral Health Skills**

Behavioral health skills, as described above ("Behavioral Health Skills Used By the Whole Primary Care Team") are used by the Clinical Care Manager when helping patients implement their treatment plan.

***Use of Community Resources**

To fully implement the treatment plan, the Clinical Care Manager is aware of behavioral health-focused resources within the practice and community and regularly connects patients to them as per the above (Self Help and Community Resource Connections).

5. Clinic System Integration Domain

***Schedule Accessibility**

The practice can facilitate the scheduling of a behavioral health and/or primary care visit for a patient at the time of a patient visit.

***Program Integration**

Primary care and behavioral health practices collaborate to promote integration at every level of the organization(s). This includes primary care and behavioral health practice leaders collaborating on developing protocols, standards of practice, memorandums of understanding, and interventions to ensure successful communication and integration. In addition, practice leadership ensures that clinical and non-clinical staff members are trained on the importance of

integration and their roles in supporting it, and provides operational support for integration in terms of scheduling, reception, administration, staffing and facilities.

***Health Information Exchange**

To the extent possible, given required compliance with federal and state privacy laws, information from primary care and behavioral health service provider visits and communications with patients are shared. This could involve having a single patient health record utilized by both the PCP and BHP. Such information exchange may require practices to actively seek MassHealth members' consent.

***Coordinated Scheduling and Same Day Visits**

The practice's scheduling allows for routine appointments with medical and behavioral health providers on the same day and has the capacity to access same-day urgent behavioral health and medical visits when needed. The practice also has the ability to access same-day mobile crisis services and other emergency evaluations.

Extent of Co-Located Integration

The BHPs and PCPs can provide services in the same area of the practice regularly or when necessary.