The Integration of Behavioral Health and Primary Care in New Hampshire

Analysis and Recommendations

December 2014

Research conducted by:
Cherokee Health Systems

Underwritten by:
Endowment for Health

Executive Summary

The New Hampshire Endowment for Health, and its subsidiary, Health Strategies of New Hampshire, contracted with Cherokee Health Systems (Knoxville, Tenn.) to conduct an assessment of the state of primary behavioral health integrated care implementation across the state of New Hampshire. Specifically, the Endowment asked for a point-in-time snapshot of where various providers are in terms of integrated care practice, and to identify the existing barriers that inhibit the advancement of the practice. Additionally, the Endowment asked for examples of effective models and contributing factors that encourage the growth and implementation of the practice, as well as for some strategies and recommendations based on Cherokee Health Systems' work in dozens of other states. The Endowment is recognized for its leadership in this project, especially in its advocacy for better health practices and outcomes of the State's citizens, and for fostering its own mission through this process in order to "improve the health and reduce the burden of illness for the people of New Hampshire – especially the vulnerable and underserved."

Primary behavioral health integrated care is a practice that leverages the utilization of behaviorists in a primary care model to achieve improved patient outcomes and health cost savings. Recognizing the self-evident connections between behavior, mental health (including substance use) and physical health, an integrated practice empowers providers to positively impact health outcomes in individuals and populations alike. Through the utilization of a specially trained and uniquely skilled behaviorist and well-trained patient-centered medical team, patients are activated in their wellness, and become better educated about their health, and more resilient in their self-care. The healthcare system, meanwhile, realizes significant cost savings through such significant factors as decreased utilization of hospital days and less emergency room services. Cherokee Health Systems surveyed dozens of organizations, interviewed many stakeholders, policymakers, and payers, and visited a representative sampling of provider sites to assess the current state of integrated care in New Hampshire, and to find examples of progress and advancement of the model.

The assessment revealed that while there are certainly pockets of innovation around the State, overall there remains room for further advancement. The primary care clinics, including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and hospital-affiliated clinics, simply out of need, import behavioral health practices in an array of methods around the State. These efforts include the co-locating of traditional mental health care within their facilities, or contracting with mental health centers to provide regular or periodic mental health support. In fact, most every primary care clinic we surveyed and visited offered some level of behavioral health services. In most of these organizations social workers, and in a few cases psychologists, are available to the primary care population for traditional mental health services. Several community mental health centers (CMHCs) were partnering with a health center to provide access to traditional mental health care, or providing some level of primary care in their own centers (typically to a small defined population, such as those with severe and persistent mental illness). Further advancement of the model may take the shape of increased co-management of patient care, better aligned workflows, the inflow of more specially trained behaviorists to work in primary care, and sustainable reimbursement models that encourage the growth of the practice.

It is proposed that the state, stakeholders, policymakers, patient care advocates, hospital networks, and safety net providers (FQHCs, health centers, CMHCs, and substance abuse providers) consider the following strategies to advance integrated care practice in the state of New Hampshire:

- Address the shortage of a specialized workforce necessary for an Integrated Care practice;

- Work with payers and state policymakers through the rollout of the Medicaid managed care system to recognize and support integrated care practices through effective partnerships and contracts between payers and providers; and
- Educate stakeholders, policymakers, payers, and especially providers on what integrated care really is – including its operations, financing, and leadership.

Integrated Care Discussion

Why Integrate Behavioral Health and Primary Care?

The escalating and unsustainable costs coupled with disappointingly poor health outcomes of the current healthcare delivery system have catalyzed a period of flux and reform across the healthcare landscape of the United States. The high degree of fragmentation, lack of access to comprehensive primary care, and negligence of behavioral and psychosocial aspects of health are key elements of an ineffective and inefficient structure of healthcare that is in desperate need of change. The role of mental health treatment in the overall health delivery system has also undergone particularly rigorous review in light of striking data regarding the national prevalence and severity of mental health disorders. Several converging factors have supported the need to integrate behavioral health and primary care services, including:

Prevalence of Mental Health Issues- According to the most recent National Co-Morbidity Survey (Kessler et al, 2005), nearly 50% of the U.S. population will experience a mental health problem at some time during their life, 25% during a 12 month period, with median age of onset in childhood and adolescence for many psychiatric disorders.

The median delay from onset of a mental disorder to first treatment contact is, astoundingly, nearly a *decade.*

Poor Access to Mental Health Treatment- Most people with mental disorders in the United States remain either untreated or poorly treated, suffering detrimental consequences emotionally, physically, and financially for themselves, their families, and substantial loss of productivity at work (Loeppke, 2009.) The median delay from onset of a mental disorder to first treatment contact is, astoundingly, nearly a *decade* (Kessler et al, 2005).

Behavioral Health in Primary Care- A number of studies have shown that the likely point of access of mental health services was in primary medical care rather than specialty mental health. Further evidence from medical settings points to the need for behavioral health support within the primary care setting. A strong body of research suggests that between 60%-70% of physician visits are for problems that involve a psychosocial component such as noncompliance or psychological factors associated with physical disease (Follete & Cummings, 1967; Cummings, Cummings, & Johnson, 1997; Katon, VonKorff, Lin, Lipscomb, Russo, Wagner, & Polk, 1990; Kroenke & Mangelsdorff, 1989). Studies indicate that between 20-33% of all primary care patients have a psychiatric disorder. Half of these patients will seek help in the primary care setting rather than a specialty mental health setting (Higgins, 1994; Leon et al, 1995).

Adverse Impact of Untreated Mental Health- Patients with untreated psychiatric and/or psychological problems also show higher healthcare utilization and greater medical morbidity and mortality thus are more expensive to treat and have poorer medical outcomes (Trask, Schwartz, Deaner et al, 2002; Evans, Charney, Lewis, Golden, Gorman, et al, 2005; Chiles, Lambert, & Hatch, 1999; Cummings et al, 1997). Unfortunately, 33-79% of psychiatric disorders are not recognized and thus not treated or referred for

appropriate treatment (Higgins, 1994). Behavioral health issues drive 12% of emergency department visits, which result in hospital admission for 40% of these visits (Owens, Mutter, & Stocks, 2007).

Indeed, a recent summary report by the Institute of Healthcare Improvement (2014) noted, "Organizations are increasingly realizing that achieving the Triple Aim…without an integrated behavioral health strategy is virtually impossible."

Co-morbidity of Behavioral Health and Physical Health Conditions- Chronic health conditions frequently co-occur, and co-morbid physical and behavioral health conditions in particular are associated with significant increase in health care costs (Kathol, 2013; Greenberg, Kessler, Birbaum et al, 2003).

System Fragmentation- Conceptually, the separation of physical health and mental health services system is incongruent with the evidence base on the value of holistic and comprehensive care, and is a poor fit with the way the majority of individuals present for healthcare service (deGruy, 1996.) The structural divide between the clinical, operational, and financial components of physical and mental health services has resulted in inefficiencies, lower quality, increased cost, and limited access to care (Butler, Kane, & McAlpin , 2008; Lurie, Manheim, & Dunlop, 2009).

Integration of behavioral health services in primary care improves the quality of care by addressing the range of psychological factors (cognitive, behavioral, affective, social) that are influencing a person's health. Mounting evidence suggests that any strategies to improve the quality and cost-effectiveness of health care must include blending behavioral health and primary care. Overall, improved medical outcomes, medical cost-offset, and improved patient and provider satisfaction have strengthened the argument for integrated service delivery models. Documented benefits of integration of behavioral health and primary care services include:

The structural divide between the clinical, operational, and financial components of physical and mental health services has resulted in inefficiencies, lower quality, increased cost, and limited access to care.

Improved Access Incorporating behavioral health services into primary care allows patients and families to access needed services at the point of primary care (e.g. without delay of referral) and within the familiar context of the patient's "Medical Home" (Blount, 1998, 2003; Butler, Kane, et al, 2008; Strosahl, 2002; Patient Centered Primary Care Collaborative, 2001) Integration of services not only removes some barriers to care, there is also growing evidence that it is just as or more effective than referral to traditional specialty services for (Katon, 1995; Robinson, 1998),

Improved Quality- Integration of behavioral health and primary care services has been shown to result in improved health outcomes for both behavioral health (e.g. depression) and physical health (e.g. diabetes) conditions (Archer et al, 2012; O'Donohue, Byrd, Cummings, & Henderson, 2005,; Fisher & Dickenson, 2014) Further, integrating behavioral health into primary care has been identified as a promising approach to reducing health disparities among racial and ethnic minorities (Sanchez, Chapa, Ybarra, & Martinez, 2011).

Financial Benefits- Integrated service delivery models have been shown to result in significant cost savings by adequately addressing behavioral health needs, reducing unnecessary utilization of more expensive health care services, increasing coordination and communication between providers, and improving self- management of chronic health conditions (Blount, Schoenbaum, & Kathol, 2007; Chiles, Lambert, & Hatch, 1999; Melek, Halford, Perlman, 2012; Ries, 2011; Waltman, Grogan-Kaylor, 2012 .)

Improved Satisfaction- Improved provider and patient satisfaction have also been documented in integrated settings (Blount, 1998; IHI 90-Day R&D Project Final Summary, 2014).

The robust body of literature that indicates that integrating behavioral health into primary care can improve access, quality of care, and yield favorable financial outcomes (James, 2009) has prompted

leading healthcare organizations to highlight integration of behavioral health and primary care as critical to the reform of the nation's healthcare delivery system. Indeed, a recent summary report by the Institute for Healthcare Improvement (2014) noted, "Organizations are increasingly realizing that achieving the Triple Aim (Appendix A) for populations in a geographic area without an integrated behavioral health strategy is virtually impossible." Integrating behavioral and primary care services has been identified as strong healthcare delivery model designed to improve access and quality of overall healthcare (Agency for Healthcare Research and Quality, 2009; Institute of Medicine, 2001, 2006; Takach, Purington, & Osius, 2010; World Health Organization and World Organization of Family Doctors, 2008.), is a good fit with the Patient Centered Medical Home (Levey, Miller, and DeGruy, 2012) and overall healthcare reform and transformation to meet Triple Aim goals of improved quality of care and patient experience at reduced cost (IHI 90-Day R&D Project Final Summary, 2014; Collins, Hewson et al., 2009)

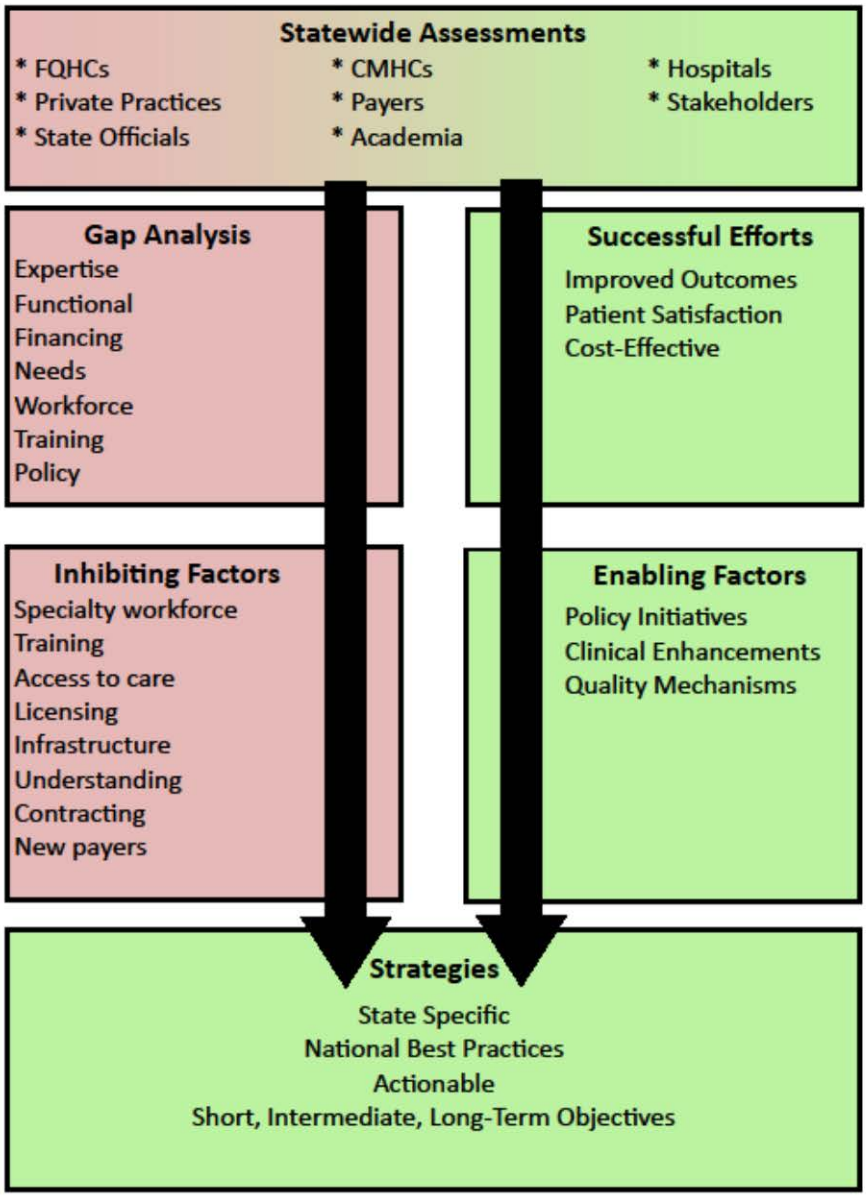
Methodology

To undertake this study, we first needed to fully understand the scope of the task as assigned by the New Hampshire Endowment for Health, its subsidiary, Health Strategies of New Hampshire, and its stakeholders. Anecdotally the study was to conduct a "state of the state" on the implementation of behavioral health and primary care integration in the New Hampshire. With an ultimate goal to improve health outcomes and reduce New Hampshire health care costs by promoting behavioral health and primary care integration, the Endowment specifically required that the study:

- Provide a snapshot of New Hampshire integrated behavioral health and primary care integration models in various practice settings, including utilization of a standardized framework to understand levels of integrated care and common themes and significant differences among these models;
- Highlight successful integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness;
- For practice settings with integrated models, highlight gaps in the range of available behavioral health and primary care expertise, role functions, and services and the reasons for those gaps (e.g. access to psychiatric consultation in primary care, intensive care coordination for patients with more acute behavioral health needs, access to specialty care, prevention/early intervention);
- Identify enabling financing mechanisms for existing behavioral health and primary care integration models;
- Identify practice, policy and financing barriers to behavioral health and primary care integration in New Hampshire;
- Identify specific state options, based on national literature and best practices, including actionable recommendations to create a more integrated health system. Recommendations should include shore, intermediate and longer term actionable steps that lay out a clear change process for adoption of behavioral health and primary care integration; and
- Inclusion of an executive summary of key findings.

The following illustration is an overview of the process Cherokee Health Systems undertook to meet the objectives described above.

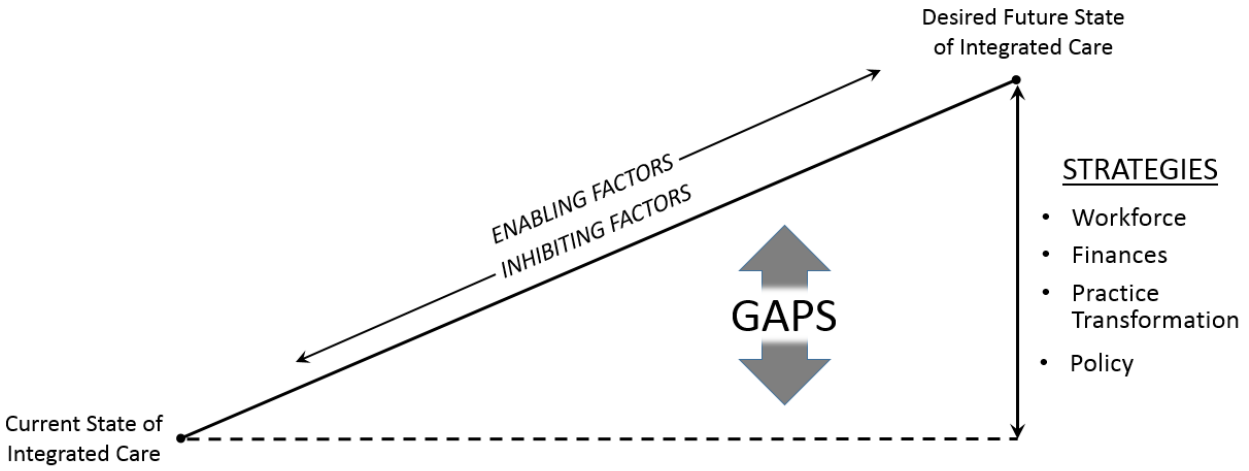
(Figure 1: Study Workflow)



We completed a comprehensive assessment of what a variety of providers throughout the state knew about, and were implementing, in regards to primary behavioral health integrated care. From those assessments, observations, interviews and data collection, we completed a gap analysis to better understand the inhibiting factors. We also identified several successful efforts and examined the factors that promote integrated care. Later in this report you will find the strategies we developed to help advance integrated care practice throughout the state.

This illustration (Figure 2) depicts the process in yet another view, showing how the strategies that are developed in terms of workforce, financing, practice transformation and policy address the gaps. These

strategies may be based on enabling factors that already exist, or in fact, the development of those enablers may be part of the strategies themselves.



Based on our experience of working with well over 200 organizations and dozens of state policymakers and associations, we revised our proprietary assessment tool, scaling it for a broader range of providers. The Primary Behavioral Health Integration (PBHI) Status Assessment Tool (Appendix B) provides a point-in-time snapshot of where an individual organization is in terms of its integrated care practice across five domains:

- Contemplative/Pre-Contemplative (no real progress toward Integrated Care)
- Preferred Referral/Initial Stage (refer out to specialty care – no on-site services)
- Co-Location of Care (either at one site or bidirectional via two provider organizations)
- Enhanced Co-Location (some qualities of integrated care, but still generally co-located)
- Fully Integrated Practice

These domains are cross-walked with eight Defining Clauses. The clauses are defined in the Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus (Peek, CJ and the National Integration Academy Council. AHRQ Publication No. 13-IPOO1-EF, Rockville, MD, 2013). The clauses, in brief, guide the reviewer through the following factors:

- A practice that is patient-centered and tailored for the individual needs of each patient;
- Has shared operations, workflows, and practice culture;
- Staff has had formal or on-the-job training in preparation for the clinical roles of integrated care;
- The practice is population-based, sharing patients and mission;
- The practice utilizes a systematic clinical approach;
- It is supported by a population that expects and demands that behavioral health and primary care will be integrated as the standard of care;
- It is supported by office practice, leadership alignment, and sustainable business model; and
- It is supported by a continuous quality improvement and measure of effectiveness process.

Each Defining Clause has a specific descriptor across the five domains of what may be most reflective of the individual practice in that specific clause. For example, under the "shared operations, workflows, and practice culture" clause, one of the descriptors states: *May share a facility, but have little formal interaction; referrals (i.e. for mental health care) exchanged in the traditional manner. May or may not be in bi-directional approach (i.e. through a partnership with a health center and mental health provider where some level of service from each is provided at both provider sites).* This descriptor is cross-walked

under the domain of Co-Location of Care; which indicates to the evaluator that at least in this particular Defining Clause, the organization is best described as a "Co-Location." Once all of the Defining Clauses are assessed and recorded, the evaluator is able to assess through scoring of the Defining Clauses an overall domain that best describes the organization. To quantify these results, we assigned a number score to each of the domains, 0-to-4; zero for Contemplation, one for Preferred Referral, two for Co-Location, three for Enhanced Co-Location, and four for Fully Integrated. A review of the results of this assessment will follow in this report.

Following the development of the PHBI Status Assessment Tool, we met with an advisory council organized by the Endowment on August, 18, 2014, at the New Hampshire Audubon Society. There were 22 stakeholders in that initial meeting where we reviewed our plan, timeline and deliverables, and sought active feedback and advice from them. Prior to the meeting we developed a database approximately 60 informants including all of the hospitals, Federally Qualified Health Centers (FQHCs), community health centers (CHCs), Community Mental Health Centers (CMHCs), and a number of stakeholders including policymakers, payers, state officials and various associations. The council provided us with 20-25 new names and organizations, and several participants offered to help us make connections with various contacts on the list. After the meeting with the Advisory Council, the Endowment hosted a series of small group meetings at the Endowment's Concord, NH, office. There we were scheduled to meet with representative from four different sectors: Community Mental Health (New Hampshire Community Behavioral Health Association, Riverbend CMHC, Community Mental Health Center of Nashua), FQHCs (Mid-State Health Center, Goodwin Community Health Center, Child Health Services), Substance Abuse (New Futures, New Hampshire Charitable Foundation, New Hampshire Providers Association, New Hampshire DHHS Bureau of Drug and Alcohol Services), and the DHHS Office of Medicaid Business & Policy. We were able to derive more specific information from these groups about their specific interests.

We began making contact with the people and organizations on the database. The database was divided by providers and stakeholders, with two of our team members calling the stakeholders and hospitals, and three focusing on FQHCs, CHCs, CMHCs and other providers. For the providers, we used a standardized questionnaire based on the PHBI Status Assessment Tool that helped us categorize the respondents across the domains. For the stakeholders, our team engaged them in key informant interviews to assess their knowledge of integrated care, and of what, if any, obstacles and opportunities they were aware. For the provider respondents, we completed initial screening and evaluations, scoring them as appropriate. We identified a list of 15 provider organizations that scored between Co-Locations and Fully Integrated on our scale. Of those, we were able to secure appointments for on-site visits at 11 of them (some declined either due to other priorities or key staff being out of town). At the same time, we were able to secure meetings with 17 stakeholders.

Utilizing the PBHI Status Assessment Tool we surveyed 38 organizations on their current state of integrated care. We contacted an array of providers from hospitals, hospital-owned health centers, community health centers, Federally Qualified Health Centers, community mental health centers, and substance abuse providers. We grouped them in the following domains; in the next section, the Findings section, we share data about the scores attained and some brief discussion:

<u>Hospitals (9):</u>

- Weeks Medical Center
- Androscoggin Valley Hospital
- Littleton Regional Hospital
- The Memorial Hospital

- Speare Memorial Hospital
- Alice Peck Day Memorial Hospital
- Frisbie Memorial Hospital
- Wentworth-Douglass Hospital
- Concord Hospital

Primary Care/Community Health/FQHC (17)

- The Counseling Center of Nashua (Dartmouth-Hitchcock)
- Ammonoosuc Community Health Services
- Goodwin Community Health Center
- Coos Family Health Services
- Families First Health Center
- Health Care for the Homeless Project
- HealthFirst Family Care Center
- Indian Stream Health Center
- Lamprey Health Care
- Manchester Community Health Center
- Child Health Services
- Mid-State Health Center
- White Mountain Community Health Center
- Capital Region Family Health Center
- Charlestown Family Medicine
- Newport Health Center
- Wentworth-Douglass Hospital Clinic

Community Mental Health Centers/Substance Abuse Providers (12)

- Northern Human Services
- West Central Behavioral Health
- Genesis Behavioral Health
- Riverbend Community Mental Health Center
- Monadnock Family Services
- Greater Nashua Community Mental Health Center at Community Council
- Community Mental Health Center of Greater Manchester
- Seacoast Mental Health Center
- Community Partners
- Center for Life Management
- Child and Family Services
- Harbor Homes

Between September 29 and October 1, 2014, our entire team of five was in New Hampshire to meet with the arranged sites and stakeholders; one team member returned on October 24, 2014, to meet with four organizations and stakeholders that were added since the first visit. Those we interviewed on-site were:

- Goodwin Community Health Center (Somersworth, NH)
- Riverbend Community Mental Health Center (Concord, NH)
- Capital Region Family Health Center (Concord, NH)
- North Country Health Consortium (Littleton, NH)
- Mid-State Health Center (Plymouth, NH)

- Families First Health Center (Portsmouth, NH)
- Lamprey Community Health Center (Raymond, NH)
- Child Health Services (Manchester, NH)
- Harbor Homes (Nashua, NH)
- Keene-Cheshire Medical Center (Keene, NH)

Additionally, we met (and/or interviewed by phone) with the following stakeholders on September 29-30, or October 24, 2014:

- New Hampshire Providers Association
- New Hampshire Healthy Families
- Cenpatico
- Well Sense Health Plan
- Bureau of Public Health Services
- National Alliance on Mental Illness – New Hampshire
- New Hampshire Department of Health and Human Services
- Harvard Pilgrim Healthcare
- New Hampshire Homecare Association
- Citizens Health Initiative
- Technical Assistance Collaborative, Inc.
- New Hampshire Hospital Association
- Office of Governor Maggie Hassan

Once all of the provider assessments, interviews, site visits, and meetings were complete, we utilized a virtual clearinghouse web-based product (Huddle) to store all of our notes, observations and documents in an easily accessible format. We met virtually several times to synthesize our data and observation in order to organize it into information by which to design the recommendations and strategies you will find later in this report.

Findings

We completed an environmental scan of the State of New Hampshire that included an assessment of the current state of implementation of an integrated care practice at a representative sample of providers, as well as a review of the payer and policy environment in the state.

State of Integrated Care in New Hampshire
Table 1 shows the average scores by domain on the PBHI Status Assessment Tool 0-4 scale:
(Table 1)

Domains	**Average Score**	**Count**
All	1.58	38
Hospital	1.44	9
Primary Care/Community Health	2.24	17
Community Mental Health/SA	0.75	12

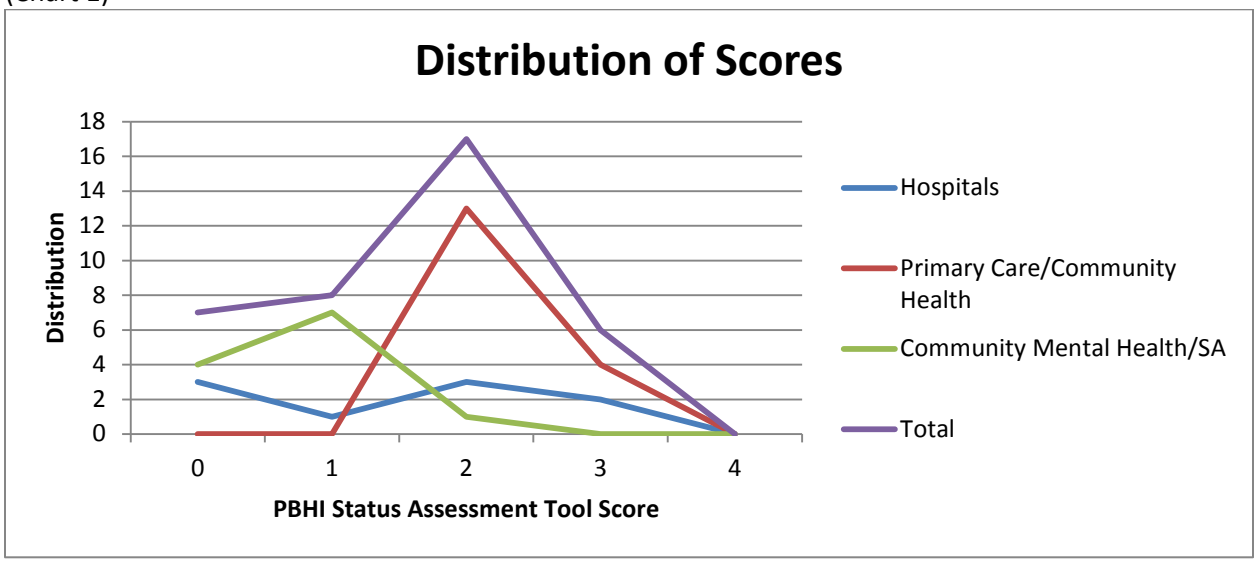
Scale:

0 – Precontemplative/Contemplative Status
1 – Preferred Referral Status
2 – Co-Located Care Status
3 – Enhanced Co-Located Care Status
4 – Fully Integrated

Table 2 shows the distribution of scores attained in each domain:
(Table 2)

Score	0	1	2	3	4
Hospitals	3	1	3	2	0
Primary Care/Community Health	0	0	13	4	0
Community Mental Health/SA	4	7	1	0	0
Total	7	8	17	6	0

A graphical look at the distribution of scores:
(Chart 1)



As part of the Payer and Policy environmental scan, we utilized financial reporting data from the New Hampshire Department of Justice Office of Attorney General – Community Benefits Plan (2013) website (http://doj.nh.gov/charitable-trusts/community-benefits/reports-2013.htm), the United States Health Resources & Services Administration (HRSA) Uniform Data System website (http://bphc.hrsa.gov/healthcenterdatastatistics/index.html), and Guidestar (www.guidestar.org) to collect data. It is important to be informed that not all data was uniformly reported across all of the domains; for example, not all of the health centers and community health centers reported certain Medicaid and Medicare data. In those situations, only the organizations that reported full data sets were utilized in this analysis as a way to at least gain a representative sample of the providers and domains. Further, this data is from Fiscal Year 2012. This data assists to better understand the payer distribution across the sectors.

Table 3 shows the percentage of patient revenue attributed to Medicaid and Medicare in the representative samples:
(Table 3)

	% Medicaid Revenue	% Medicare Revenue	Sample Count
Hospitals	5.46%	37.14%	9
Primary Care/Community Health	29.79%	28.39%	6
Community Mental Health/SA	88.46%	2.14%	4

Table 4 shows the percentage of costs associated with each payer. In other words, if the Medicare cost for hospitals is 131.41%, it costs the hospitals approximately $1.31 to collect $1.00 in Medicare payment.

(Table 4)

	% Medicaid Cost	% Medicare Cost	Count
Hospitals	156.57%	131.41%	9
Primary Care/Community Health	115.14%	144.34%	6
Community Mental Health/SA	94.57%	108.90%	4

To better understand the context of mental health spending in New Hampshire in comparison with other states, we analyzed information from the National Association of State Mental Health Program Directors Research Institute pertaining to the per capita dollars allocated to mental health services. This information (Table 5) was corroborated with data from the Henry J. Kaiser Family Foundation. The information reveals that New Hampshire ranks 17th nationally in per capita mental health services expenditures.
(Table 5)

Location	SMHA Expenditures Per Capita
1. District of Columbia	$360.57
2. Maine	$346.92
3. Alaska	$310.01
4. Pennsylvania	$280.78
5. New York	$256.31
6. Vermont	$239.84
7. Arizona	$221.27
8. New Jersey	$200.09
9. Connecticut	$189.34
10. Montana	$173.59
11. Hawaii	$169.99
12. North Carolina	$165.75

Location	SMHA Expenditures Per Capita
13. Maryland	$164.11
14. Oregon	$157.08
15. California	$152.60
16. Minnesota	$150.18
17. New Hampshire	$146.40
18. Iowa	$134.46
19. Wyoming	$133.24
20. Kansas	$132.33
United States	**$120.56**
21. Michigan	$119.23
22. Mississippi	$114.95
23. Washington	$113.57
24. Massachusetts	$109.07
25. Wisconsin	$108.15
26. Delaware	$106.04
27. North Dakota	$96.37
28. New Mexico	$93.37
29. Virginia	$90.72
30. Rhode Island	$90.51
31. Colorado	$88.41
32. Missouri	$86.75
33. South Dakota	$85.35
34. Indiana	$81.73
35. Nebraska	$80.73
36. Illinois	$80.43
37. Alabama	$78.19

Location	SMHA Expenditures Per Capita
38. Tennessee	$77.40
39. Ohio	$73.13
40. West Virginia	$72.88
41. Nevada	$68.32
42. Utah	$64.17
43. Louisiana	$62.37
44. South Carolina	$59.75
45. Kentucky	$53.69
46. Oklahoma	$53.05
47. Georgia	$46.54
48. Arkansas	$42.02
49. Florida	$39.55
50. Texas	$38.99
51. Idaho	$36.64
52. Puerto Rico	$22.97

(National Association of State Mental Health Program Directors Research Institute, http://www.nri-incdata.org/. Accessed November 24, 2014)

Discussion of Key Findings

Central to our initial task was to ascertain the status of Primary Behavioral Health Care Integration in the state of New Hampshire. The data indicates:

1. There are pockets of practice advancement throughout the state, but widespread knowledge of, and implementation of the practice is lacking;
2. The primary care sector (Federally Qualified Health Centers, hospital-owned outpatient clinics, Rural Health Clinics, etc.) is clearly more advanced in integrated care practice implementation than the mental health/substance abuse sector;
3. While most primary care providers state that they are "integrated," they are more closely associated with a co-location model. Hallmarks of co-location in New Hampshire include segregated documentation of behavioral health services, behaviorists that are doing primarily traditional mental health services in the primary care setting, mental health

centers that offer limited primary care services to specific populations within the confines of their centers, very little communication and co-management of patient care between behaviorists and primary care providers. Some providers are more advanced in one or more of these hallmarks, but none that we found were advanced to the level of being fully integrated.

4. We heard much frustration from providers about the difficulty of staffing its workforce, specifically if it wanted to fully integrate its services. This was seen as an inhibiting factor to the progress of implementation. Factors included difficulty in finding qualified behaviorists, confusion of licensing requirements, an extreme shortage of psychiatry, and an overall aging workforce. Our analysis revealed that while workforce shortages do exist in some localities and disciplines in New Hampshire, as a state New Hampshire's supply of providers is relatively high in comparison to other states and the nation.
5. Many providers voiced concern about payer mixes, the transition to managed care, and the high cost of providing integrated care – which many felt was simply not reimbursable – as an inhibiting factor. Our analysis of the data confirms some of these concerns, specifically the high costs of service delivery. Yet, again, when compared on the national scale New Hampshire's healthcare expenditures – specifically in the provision of mental health services – ranks nearly in the top third of all states and territories.
6. There was almost universal frustration from the primary care and hospital providers on lack of timely access to mental health services in their communities.

Examples of Efforts and Advanced Practices

In July, 2015, and November, 2015, the Health Resources and Services Administration (HRSA) released 433 grants worth nearly $106 million to health centers across the country to expand mental health services in primary care. Five health centers in New Hampshire were awardees of these funds:

- Harbor Homes
- Goodwin Community Health Center
- Lamprey Health Care
- Manchester Community Health Center
- City of Manchester (Healthcare for the Homeless Project)

These funds will infuse over $1.1 million combined to these organizations to hire new mental health professionals, add mental health and substance use disorder health services, and employ integrated models of primary care. It is interesting to note that the original announcement of these funds was made by Vice President Joe Biden during a speech at Sandy Hook Elementary School, and that the Administration believed the best allocation of these funds was to the community health system. HRSA recognizes the prevalence of mental health and behavioral issues that present in primary care, and is equipping its community health centers with more resources to address these issues. These funds will assist these five organizations with not only hiring behavioral specialists, but could also provide for training and technical assistance that may be eventually shared with other safety net providers.

In regards to this study, we assessed a number of organizations through on-site visits and telephone and web-based surveys. Efforts toward integration generally fell within four common approaches:

- Preferred referral model
- Partnerships
- The use of a consulting psychiatrist
- Embedded behaviorists

There are several active **partnerships** between primary care providers and community mental health centers in the state. Several that we visited included:

- Community Mental Health Center (CMHC) of Greater Manchester, Manchester Community Health Center, and Child Health Services: Child Health Services and the Manchester Community Health Center were in the midst of a merger during our visit. The Manchester Community Health Center already had an existing partnership with the CMHC of Greater Manchester. The services offered by Child Health Services were determined by our team to be advanced in the following areas: They provide a comprehensive family assessment for each new family that enrolls in the services of the pediatric clinic. The provider team is staffed with a pediatrician, nurse, dietician and social worker. Having provided this service for at least two decades, it may be the first patient-centered pediatric medical home in the state. The clinic was also recently awarded NCQA Level 3 Patient-Centered Medical Home recognition. The providers and administrators we spoke with were optimistic about the potential of the merger and the ability to access the different levels of care and improve access to and communication between specialty providers. They were also discussing their challenges of understanding the cultural and operational differences between not only primary care and mental health services; but also between the intensive patient-centered medical home services of the pediatric clinic, and the population-based services of the community health center. There was concern by the pediatric providers that they would not be able to continue to offer the level of care their patients have come to expect due to the federal guidelines and regulations of the community health center.
- Seacoast Mental Health Center: Based in Portsmouth, the Community Mental Health Center has partnerships with three local FQHCs where it provides psychiatry support and social workers who visit the primary care sites on a regular basis.
- Greater Nashua Counseling Center and Dartmouth-Hitchcock Hospital: This is an interesting partnership between "for profit" and "not-for-profit" organizations; a relationship that presents challenges on its own. However, there is a strong spirit of collaboration and expansion of behavioral health services in primary care. An advanced practice in this partnership is that there is a firm understanding of the leadership of what true integrated care looks like, and a genuine desire to work toward it. A common theme heard here as in many other sites around the state is that the desire to implement integrated care is at least partially fueled by a lack of access to and coordination with the local mental health systems.
- White Mountain Community Health Center: An independently operated not-for-profit health center in Conway, White Mountain CHC receives no federal grants or funding. It is a

Practices that Advance Integrating Care:

Comprehensive Family Assessments

Multidisciplinary Patient-Centered Team

Strong Leadership with Clear Vision

Daily Team Huddles

Embedded Behaviorists

Training Interns

Psychologists and Nurses Working Together

Behaviorists that are Accessible to the Primary Care Team

product of a merger between Children's Health Center and Family Health Centre. It contracts with a local mental health provider for a psychiatrist to spend time once a month at the center reviewing charts and consulting with providers. The clinic employs a social worker who sees patients for traditional mental health services. A practice of note at White Mountain is its daily huddle; each morning the provider team gathers to review potential challenging cases and coordinate their day.

There are also several outstanding examples of practices that utilized **embedded behaviorists** in the primary care team:

- Cheshire Medical Center/Dartmouth-Hitchcock Keene: The embedded behavioral health services at Cheshire Medical Center in Keene may be one of the longest tenured such practices in the state. The hospital has a Behavioral Health Team that meets regularly to review practices and provide team updates. There are two psychologists on the team that provide traditional mental health services, but have a desire to transition to more brief interventions in primary care and services that support primary care. "We've never really said that we provide behavioral health care, but that's exactly what we do," one of the nurse care managers reported during our visit. An excellent practice at this site is the use of psychologists and nurses working together to provide multidisciplinary care. The team has participated in several studies and efforts in the past that focused on providing behavioral health support to patients with depression and diabetes. This is a practice that has the potential to transition to a fully integrated model with minimal support and policy changes with payers.
- Capital Region Family Health Center/Concord Hospital: Providing primarily a co-location of traditional mental health providers to a primary care practice, this model also has potential to easily transition to a fully integrated model with some further technical assistance and policy support. Examples of advancement at this site are the behaviorists are accessible to the primary care team. One behaviorist made the observation that the more she is visible and active on the primary care floor, the more she is utilized. Another hopeful practice is that the organization is a training site for interns; this provides a wonderful opportunity to introduce them to this practice.
- Goodwin Community Health Center: The primary care providers are passionate about the benefits of the embedded behaviorists at their practice. The organization has worked hard to solve many of the challenges of blending the work of the behaviorist into the busy flow of primary care.
- Families First and Wentworth-Douglass have behaviorists who work closely with primary care providers and can accept patient "hand-offs" at the point of care.
- Several other organizations indicated an interest in the embedded behaviorist model but stated they need more information about the operations of the model and that they were awaiting shifts in policy that would encourage and incite such expansion.

Common challenges that were consistent at many of these organizations included the following:

1. Confusion over what is billable and what isn't. There was wide variation of opinion across the state about the status of the CPT 96150-96155 Health & Behavior codes; specifically if they were accessible by providers, and if so, by what licensure?
2. Questions about same-day billing. There is much confusion as to whether providers – FQHCs or otherwise - can bill two services in one day. According to a letter to our team from the Bi-State Primary Care Association (October, 2014), "FQHCs are permitted to bill separately for different types of services provided on the same day as outlined in the FQHC Billing Manual." The Association is advocating for the same-day allowance for non-FQHC providers as well.
3. Lack of access to and communication with the local mental health and substance abuse providers. Primary care providers complained of six-to-eight week waits for appointments and consistently poor communication between the organizations.

Common Challenges:

Confusion with the Use of CPT 96150-96155 H&B Codes

Questions about the Ability to Bill Two Services in One Day

Lack of Access to and Communication with the Local Mental Health and Substance Abuse Provider

Possible Strategies and Considerations

Workforce

What We Heard:

Key informants told us that the behavioral health workforce is in desperate straits, and the primary care workforce is experiencing significant shortages as well. There is a perception that there is a serious shortage of qualified behavioral health staff to meet the needs of the communities being served by providers. This is particularly true with integrated care staff. Behaviorists with skills to work in primary care (Behavioral Health Consultants) are especially hard to find. This was a constant theme from FQHCs, CMHCs, private providers, and hospital-based practices. We did not hear of any psychiatrists who base their work in a primary care setting. Referrals to established behaviorists in the community experience extremely long wait periods. This is particularly true in more rural, underserved areas of New Hampshire. Patients and providers are desperate for a coordinated, well-trained behavioral health and primary care workforce.

"We practice in isolation. There are few opportunities for us to get together."
Family Physician

We also heard that licensing issues/barriers result in qualified staff seeking employment in other states rather than New Hampshire. We also heard that provider credentialing is often delayed, resulting in the loss of staff to other states, or long delays in bringing staff on board or the provision of care that is uncompensated.

The US Health Workforce Chartbook (HRSA, Nov. 2013) reveals that New Hampshire ranks among the states with the highest number of physicians, nurse practitioners, and physician assistants per 100,000 residents and is mid-tier in the number of psychologists and social workers. Given the feedback from key informants, however, there is likely mal-distribution of these providers across the state. Also, it should be noted that the physician, nurse practitioner, and physician assistant data did not differentiate between primary care providers and specialty providers.

A workforce strategy consisting of the following steps is recommended to increase the New Hampshire Integrated Care workforce supply and quality.

Workforce Strategy:

1. Discuss a Workforce Plan that articulates the number and type of workforce needed throughout the State to effectively staff integrated care. Utilizing short-term, intermediate, and long-term goals, or "reach goals," to best manage the process may be helpful.

2. Consider strategies that would increase the number of behavioral health training programs (please note that our definition of behavioral health includes both mental health and substance abuse conditions), and/or expand existing training programs in the State, in order to produce greater numbers of psychologists, social workers, licensed drug and alcohol counselors, psychiatrists, and other professionals. Collaboration with academic institutions to increase the supply and quality of Integrated Care behavioral staff has been a point of interest in other areas in the country and might be considered in New Hampshire. Training grants or other incentives to encourage expansion of academic programs based on best practices may benefit the workforce. It is our understanding that Antioch University is taking directed steps to this end and it is hoped that its efforts are supported and highlighted.

3. Advocacy for policy changes that promote the improvement of the "pipeline" of behavioral health professionals training at the graduate level in Integrated Care may be considered. For example, the expansion of the dispensation for billing for Medicaid services for trainees enrolled in an accredited graduate level program practicing under the supervision of a licensed professional the trainees field of study to CHCs/FQHC settings. This opportunity is currently only available for community mental centers settings. Medicaid reimbursement for services provided by trainees and safety net primary care settings will provide funding for graduate student training. Training programs in the state identified this as a major barrier to expanding their educational efforts in integrated primary behavioral health in their graduate programs. Since providers-in-training frequently choose to stay where they train, this strategy will increase the number of appropriately skilled behaviorists in the State's primary care workforce

4. Examine the potential of licensure reciprocity agreements with other States (both contiguous to New Hampshire and noncontiguous) to reduce or remove licensure barriers for behaviorists and other licensed staff seeking employment in New Hampshire.

5. Encourage the development and implementation of expanded telemedicine within the State. An environment of technical innovation, infrastructure development, licensure and rulemaking innovations, and payment for all telemedicine codes may increase access to care through increasingly available technologies, such as tablets, smart phones, patient portals,

etc. Dartmouth College is noted as a leader in this sector and may be a wonderful resource and partner in this effort.

6. Increase the quality and skill set of the New Hampshire Integrated Care workforce by providing Integrated Care Continuing Education opportunities for primary care providers, behaviorists, administrators, and others in the "nuts and bolts" of Integrated Care clinical and operational procedures.

7. Provide Integrated Care Continuing Education on a no-cost (or low-cost) basis to providers interested in developing their Integrated Care skill sets. Beyond the efforts already unfolding at Antioch University and Dartmouth College, the State might engage Community Colleges and Undergraduate Schools in discussions about training programs (on-site and/or online) and continuing education for care coordinators, care managers, case managers, patient engagement specialists, certified coders, and others needed to implement value-based contracts in order to develop a stronger Integrated Care workforce. Take advantage of existing Webinars and Integrated Care training programs throughout the country to improve skill sets. The development of leadership capabilities among practice administrators to implement integrated care throughout the state is vital. Leadership's vision and commitment to not only their respective organizations but to the overall health of the people of New Hampshire will cause these integrated care initiatives to either succeed or fail.

Finance

What We Heard:
In a word, CONFUSION. Key informants told us there is general confusion among the FQHCs, CMHCs, and other providers regarding correct integrated care coding and billing policies and procedures. In particular, providers are unclear whether billing for two services on the same day is allowable and whether the Health Behavioral and Assessment CPT codes will be reimbursed. Many organizations felt they were losing significant dollars due to inaccurate and unclear billing and coding practices.

We heard that most providers believed there are simply not enough financial resources to effectively implement Integrated Care at their organizations or across the State. Some providers, especially the CMHCs, claim to be financially fragile and are experiencing challenges as their revenues decrease (or remain constant) while expenses increase. Hospital-based practices appear to be in a stronger financial position than free-standing safety net providers and provide a significant opportunity to effectively implement Integrated Care statewide due to their geographic distribution, size, staffing, market share and financial position.

"There is no real alignment of dollars, outcomes or anything else. There are few incentives to treat the whole person."
Policy Representative

Payers told us they are interested in achieving increased value (which they define as higher-quality with lower costs) and are willing to develop and negotiate innovative, incentive-based, and/or value-based contracts. Many organizations are discussing value-based contracts, but

there seems to be less clarity about what they actually look like and how much risk-sharing should occur.

Finance Strategy:

1. Confirm that Health Behaviors and Assessment CPT codes 96150-96155 are being reimbursed by Payers.

2. Confirm that Payers in the state are paying for same-day services by a primary care provider and an embedded behaviorist.

3. Insurance Carriers/Payers should be encouraged to conduct Integrated Care coding training with providers throughout State, with particular attention to integrated care codes such as the 96150 codes, E&M codes, other primary care and behavioral health CPT codes, diagnosis codes, and same day billing policies and procedures. We recommend that this type of training occur at least annually.

4. Negotiate fair contracts with all payers to pay "fair and reasonable" reimbursement rates for all healthcare services performed by Integrated Care providers. This should include payment for certain codes, but also include a per-member/per-month (PMPM) for integrated care management services.

5. Provide technical assistance to practices interested in expanding Integrated Care. Since embedding a behaviorist within the primary care team changes workflow, billing, clinical policies and procedures, and operations, we recommend voluntary practice assessments and written reports to Leadership to determine opportunities for Integrated Care practice transformation, improved efficiency, same day scheduling, improved patient flow, etc. To achieve expected savings and quality improvements, it is imperative that integrated care be done correctly, which will require important changes in the clinical model and the administrative and financial infrastructure to support it.

6. If the State is successful in gaining approval of the 1115 Waiver Application (see definitions for more information), these resources will be available to support integrated initiatives.

7. Shift from volume-based provider contracts to value-based provider contracts over the next one to three years. The State should encourage the development and expansion of value-based provider contracts, assuring fairness and limiting provider risk exposure. Ideally, early value-based contracts will provide only "upside" risk for providers, until providers develop the infrastructure and practice transformation needed to manage risk. This single strategy will have the greatest impact on changing the direction and pace of integrated care in New Hampshire.

> **"If you don't want to do fee-for-service, tell us what you want!"**
> Payer Representative

We have found value-based contracts often include the following:

a. Base reimbursement amounts for all value-based provider contracts should be based on percent of Medicare (for example), and should not be at risk. Bonus dollars should be paid over and above the base rate reimbursements.

b. A Coordination of Care Administration Capitation PMPM amount over and above the Base Reimbursement in order to help fund providers for practice transformation, patient engagement, quality enhancements and care coordination. The Coordination of Care Administrative Capitation amount may vary based on different patient populations and their expected severity of illness. For example, different rates might be paid for Non-Dual Aged, Blind and Disabled (ABD) members and TANF/Medicaid members. Due to Medicare patients' complexity, it is recommended that Medicare members not be included in the initial scope of any incentive terms, but may be included later. However, this could vary based on provider risk-taking confidence and level of practice transformation.

c. Quality Performance Standards negotiated between the payers and providers. For example, the parties could negotiate up to ten (10) HEDIS metrics which would be eligible for extra bonus dollars. These metrics should target outstanding population health needs, such as diabetes, high blood pressure, cardiovascular disease, asthma, etc. In order to have the greatest impact. Including specialty behavioral health providers in tracing health outcomes will incent integrated practice and the enrollment of high risk patients in primary care.

d. Quality Performance Thresholds for incentive compensation can be negotiated for, for example, six (6) or more of these HEDIS measures which need to be met before the provider receives any quality bonus dollars. This gives the provider the opportunity to receive additional infrastructure funding while providing a negotiated level of quality. Of course, the importance of these dollars is to change the payer and provider foci from volume to measurable quality.

e. Future value-based contracts may eventually include shared-risk around a mutually agreed-upon medical loss ratio (MLR) corridor and the development of a medical expense fund with shared surplus and shared deficit provisions. (We would encourage contracts with only shared surplus provisions until providers achieve the infrastructure and practice transformation necessary to be at risk for shared deficits). Of course, value-based contracts with MLR provisions focus providers' attention on managing medical loss ratios of patients assigned or attributed to them by the payers, and requires providers to understand the risks attendant with managing MLR's and in developing the skill sets to effectively engage patients, coordinate care, and use data analytics.

8. Integrated Care providers might find benefit in organizing or joining formal Strategic Alliances, Individual Practice Associations, Accountable Care Organizations, and/or consider Organizational Mergers as value-based, risk-sharing contracts eventually modify or replace current volume-based contracts. Smaller providers without a strong network to support their infrastructure and practice transformation needs will be at a significant disadvantage,

financially and operationally. In addition, payers will be less interested in contracting on a full-risk basis (capitation) with smaller providers, since the "law of large numbers" will not apply to their patient populations. In our experience, collaborations between FQHCs and CMHCs have been problematic. There are significant challenges between their respective missions, culture, resources, reimbursement strategies, electronic health records, database management, workflow, legal requirements, governance, etc. We believe more formal arrangements, as mentioned above, including mergers that take advantage of respective organizational strengths, need to be considered for long-term sustainability of services. As controversial as some of these strategies may sound, we believe the survival of the safety net across the country may well depend on some degree of consolidation.

9. Payers and providers may discuss collaborating on the development of usable, easily accessible, low-cost (or no-cost) patient databases and on the healthcare informatics/analytics necessary to manage populations of patients. While the State has an all-claims payer database, few provider organizations are using it to effectively manage their patients. Clearly, data is the future and is going to drive key decisions around patient care, cost management, quality, etc. The State should provide leadership in the development of a single health information exchange (HIE) or a system of health information exchanges (HIEs) across the state that allows the "push – pull" of patient data from all providers' electronic health records, paid claims, and other data sources. These health information exchanges will provide near-term and long-term understanding of health conditions and provide greater access to information for patient engagement, care coordination, etc. Healthcare informatics/analytics need to be applied to these newly formed HIE's, in an effort to identify and manage trends in patient care, as well as individual patients. Knowledgeable health informatics specialists need to be trained and employed to report actionable data to providers, payers and the State.

> **"We can't just sit here and protect the status quo."**
> Advocate

What We Heard:

Payers commonly "carve-out" behavioral health from their primary care contracts, and subcontract behavioral health to a separate vendor. This type of structure creates challenges for integrated care providers, as they attempt to navigate both contracts. These contracts, in our opinion, support fragmentation of care and sustain "silos" of medical and behavioral care. While carve-out contracts often create operational, financial and implementation challenges for integrated care providers, they also have the potential to reinforce the stigma of behavioral health care. It is common to "carve-out" mental health and substance misuse conditions, but it is uncommon (if not unheard of) to "carve-out" other healthcare conditions such as cardiology, endocrinology, orthopedics, and so on. Cherokee has had extensive experience in managing "carve-out" contracts and understands their negative impact on integrated care.

> **"We want to design relationships to create patient-centered medical homes that reward integrated care."**
> Payer Representative

Carve-Out Strategy:
Contracts between Payers and providers should recognize and support integration. We recommend an integrated, value-based contracting arrangement without using separate carve-out vendors. A single value-based contract inclusive of both behavioral health and primary care services should be developed in an effort to reduce fragmentation and increase integration.

What We Heard:
Many healthcare providers are uneasy with the transition to a managed care environment. They are especially concerned about assuming financial risk in exchange for the opportunity to benefit when costs are well-managed. There is a trend among some providers to retain a fee-for-service payment model with the hope of protecting the status quo and obtaining favorable fee-for-service rates, rather than transforming practices to support pay-for-performance contracts. Most CMHCs used a messenger model to negotiate contracts. Contract negotiations need to, increasingly, reflect a stronger partnership between payers and providers. Adversarial, "win-lose" contract negotiations need to be replaced by a partnership model of negotiation where payers and providers joined forces to improve population health, improve quality and control costs. Financial incentives need to be in place to fund startup infrastructure needs for providers, as well as long-term sustainability of integrated care strategies.

"We need to know who we are serving, why we are serving them, what their outcomes are, and how much money we're willing to spend on those outcomes. We need to forge new and creative relationships when treating the whole person."
Policy Representative

Contract Strategy:
Providers need new skills and transparent data regarding their operations and their assigned or attributed population of patients. This requires working closely with payers to enhance patient engagement, risk stratification, health information exchanges, data analytics, care coordination and other patient management techniques. At a minimum, providers need to know their cost per visit, annual cost per patient, chronic disease management outcomes, key HEDIS metrics and the medical loss ratio for their population of patients. We recommend an intensive provider contracting "boot camp" to assist providers and understanding ways of structuring value-based contracts, and the operational infrastructure needed to support those contracts.

Practice Transformation

What We Heard:
Key informants told us that practice transformation for Integrated Care is paramount, but that few providers knew the "nuts and bolts" of what that practice transformation actually looks like, and how to achieve it. They felt that the goals of increased quality and decreased costs are commendable, but elusive. We were told on several occasions that there is concern about provider willingness and readiness for change at the practice level, and that some industry leaders may be more interested in protecting the status quo than in meaningful change.

The theme of leadership arose again and again. We heard concerns about how to actually change an organization, and manage change/transformation on a day-to-day basis.

The challenges of electronic health records were mentioned by several key informants. Concerns about reduced productivity, difficulty in communication with other collaborators using different electronic health record systems, and poor provider satisfaction were mentioned. They expressed concerns about how to effectively use the electronic health records to communicate between behaviorists and primary care providers.

Practice Transformation Strategy:

1. The State has the opportunity to lead transformation through vehicles such as Medicaid managed care contracts and, if approved, the 1115 Waiver. The State may be able to get providers "onboard" regarding the importance of Integrated Care to the State, particularly in the context of improved quality and reduced costs. Perhaps there could be more collaboration at the state level among departments responsible for primary care, behavioral health, and substance abuse. This could be a cabinet-level advisory committee that meets regularly and addresses progress toward these recommendations.

2. Provider Boards of Directors and CEOs, CFOs and CMOs are in position to provide leadership vis-à-vis integrated care. Little, if any, transformation will occur unless organizational leadership supports the transformation. Boards and executives need to be engaged in transformation through their words, behaviors and coaching of staff. Leaders need to be convinced that Integrated Care transformation is "worth it," and demonstrate that commitment throughout the organization.

3. Consider convening an "Integrated Care 101 Summit" and invite providers from across New Hampshire to better understand the "nuts and bolts" of integrated care, including clinical procedures, staffing ratios, workflows, coding, strategic planning, job descriptions, contract negotiations, etc. People attending the Summit should be team structured, including CEOs, CFOs, CMO's, CIOs, and others involved in practice management, quality assurance, and care coordination.

4. Providers should review their electronic health records in the context of meeting their long-term needs. A number of providers reported their dissatisfaction with their traditional electronic health records, and the decrease in productivity and corresponding revenue as a result of their EHR's "clunkiness." Electronic health records, to a large extent, drive provider workflow, scheduling, documentation, and follow-up. It is imperative that providers have electronic health records that provide the necessary clinical, administrative and billing documentation, but also enjoy a high degree of provider satisfaction. Providers may want to explore "cloud-based" electronic health records systems, as they investigate technologies to support integrated care. Cloud-based products often require little or no upfront capital costs and have ready data conversion capabilities. Cloud-based systems may be a viable option for smaller providers who may not have the technical resources and programming depth needed to take advantage of value-based contracts and health reform.

5. Implement Change Management training for healthcare administrators, practice managers, clinical directors, leadership, etc. Programs at New Hampshire universities should be engaged to conduct training that will help leaders and other staff to develop Change

Management skills, including vision, culture, leadership, plan-do-study-act processes, resource planning, execution expertise, lean methodologies, etc.

What We Heard:
Numerous providers told us that there are lengthy waiting lists for patients attempting to access specialty behavioral health services, especially for individuals with severe mental illness. Commonly, long wait times discourage referrals from primary care providers and other community organizations, and the time delays discourage real-time collaboration among providers. There were also concerns expressed by behavioral health providers based on capacity issues involving workforce supply, finances, no-show rates and scheduling inefficiencies.

Access Strategy:
All providers, but especially behavioral health providers, might investigate Same Day Access strategies in accordance with the national industry trend to provide more appropriate access. This will improve timeliness, efficiency and effectiveness of patient care. Consideration should be given to assessing and revising intake and assessment procedures, employing lean redesign strategies to reduce wait times, centralizing scheduling, and employing concurrent documentation as a means of improving provider efficiency.

What We Heard:
While there are a range of innovative integration initiatives across the state, many of them are occurring in isolation from one another. We learned of creative and unique partnerships and programs to integrate behavioral health and primary care that were relatively unknown. Further we consistently heard from a variety of providers that they had limited knowledge of other similar initiatives around integration in the state, which impacted their ability to learn from and partner with others. In some cases, stakeholders reported that fragmentation of integration efforts has resulted in inefficiencies and redundancies in program implementation due to duplication of effort.

> **"There are pockets of innovation throughout the state, but there is no systematic clearinghouse to transfer that innovation throughout the state."**
> Policy Representative

Collaboration Strategy:
1. Coordinate a resource directory of integration efforts in the state that is organized by target population, setting, and activity type to inform, disseminate, and promote synergy across similar and/or complementary initiatives.

2. Support a statewide learning collaborative or regional network of stakeholders interested in integration to promote collaboration, partnership and advocacy in the field.

What We Heard:
There is a lack of coordinating structure for program evaluation of integrated care efforts.

Evaluation Strategy:

1. Discuss with in-state Academic institutions – Antioch University, for example – the potential for a common set of metrics to measure integration efforts across the state of New Hampshire.
2. Consider extending this strategy to crosswalk these metrics across electronic health records— this could be accomplished through a regional health information exchange or a common data registry.

Building on the Foundation of Earlier Reports and Current Initiatives

We have been guided in our analysis of the New Hampshire healthcare environment by an array of reports and studies generated by the concerned citizens of the state, by officials within the state government including the State Legislature and faculty from New Hampshire's academic institutions. These documents not only highlight issues that need to be addressed but also provide strategies to accomplish solutions to some of the most pressing healthcare challenges for the State. These reports contributed greatly to our understanding of the relevant issues and concerns. Executive staff in State government and many citizens who had participated in the studies were most generous with their time and the perspectives they shared added insight and richness to the published reports.

In addition to the action oriented agenda of the Endowment for Health, sponsors of the study, our inquiry was facilitated by the ongoing work of the New Hampshire Center for Public Policy Studies and the New Hampshire Citizens Health Initiative. Noted researchers James Fauth at Antioch University and Michael McGovern at Dartmouth have been measuring, and thereby facilitating, the progression of integrated care in New Hampshire for some time. Their insights into the New Hampshire scene were instructive. Finally, recent initiatives by the Governor's staff and Administration articulate the themes of system transformation and payment reform, citing the integration of behavioral health with medical care as a key component of both. The previous work we reviewed harbored many overlapping themes and recommendations. In general, our findings corroborated work that has gone before and the strategies we propose will carry the delivery system in the direction the majority of those with whom we consulted would like to see occur.

A central theme on the state of healthcare in New Hampshire is the inadequate access to mental health services. The challenges faced by the community mental health system were often cited as a topic of concern. Unfortunately, this is a national trend and not unique to New Hampshire. The 2008 report, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens-- a Strategy for Restoration", laid out a 10 year plan to infuse the community mental health system with new resources and programs. Leaders in the community mental health system report limited progress to date.

Another review of the system released in the same year, "Fulfilling the Promise: Transforming New Hampshire's Mental Health System," articulated a dozen recommendations for system improvement including the following: "Develop a publicly available system of measurement and monitoring to improve practices across the mental health service system "; " Facilitate the integration of all aspects of the healthcare system so residents participate in a seamless system of care"; and "Create financing mechanisms to support implementation of evidence-based and science-based emerging practices".

From our experience and that of others across the country who provide integrated care or advocate its expansion a new service system paradigm is needed in order to match the prevalence of psychiatric disorders in our country. Traditional models of mental health care can never be enhanced with sufficient resources to match the need. However, since most of the demand for behavioral health help presents first in primary care and most of the interventions occur there, primary care is the logical place to house frontline behavioral health care. Regrettably, at this point in time most behavioral health professionals practice outside of the primary care environment.

The problem of access to behavioral health treatment is best addressed by bolstering the primary care model with embedded behavioral health specialists who can provide frontline assessment and intervention for all psychiatric disorders, triaging to specialty providers when indicated. In this paradigm most behavioral healthcare remains in the primary care environment. This takes pressure off the overloaded specialty mental health providers allowing them to manage those with the most complex psychiatric and social needs.

Since most of the demand for behavioral health help presents first in primary care and most of the interventions occur there, primary care is the logical place to house frontline behavioral health care.

A couple of reports we reviewed focused on behavioral health care for New Hampshire's children, "Children's Mental Health Services in New Hampshire: where we are now, where we need to go, how to move forward" (2009) and "Transforming Children's Behavioral Healthcare- A Plan for Improving the Behavioral Health of New Hampshire's Children" (2013). These reports echoed the access issues noted above and lamented the fragmentation and a poorly coordinated system of care to serve the needs of the children and youth of the state. Behavioral health workforce shortages were noted. "The most recent report recommended the system" maximize opportunities to integrate care."

A few months ago the New Hampshire Center for Excellence released "Substance Use Disorder Treatment and Other Service Capacity in New Hampshire". This report details the service gaps in substance abuse treatment throughout the state. The deficiencies of this system of care will be further exposed by the enhanced access facilitated by the new substance use disorder treatment benefit available to the card-carrying enrollees of New Hampshire's new Health Protection Program. Given the frequent co-occurrence of substance use disorders and behavioral health issues, the best approach to treat these conditions is to treat them together. Furthermore, since there are frequently medical complications as a consequence of substance misuse, a primary care treatment environment with embedded behavioral health expertise is the ideal treatment environment. It is well-known that many who abuse substances, legal as well as illegal, are not ready to acknowledge their problem and seek

treatment. Despite a lack of interest in treatment for their misuse of substances, these individuals are likely to approach a primary care provider with other concerns. Therefore the most effective public health approach to the rampant problem of substance misuse is to provide routine screening for these disorders in primary care with the assessment and intervention resources available via appropriately trained and skilled behaviorists available at the point of care.

Given the frequent co-occurrence of substance use disorders and behavioral health issues, the best approach to treat these conditions is to treat them together.

The State has released an ambitious plan, "New Hampshire State Health Improvement Plan 2013-2020 Charting a Course to Improve the Health of New Hampshire". Substance misuse is one of the 10 priority areas for population health improvement. The report cites the cost when these conditions go untreated and the benefits and cost reduction that results when successful treatment occurs. This comprehensive plan includes measurable objectives and targets for health outcomes. It calls for delivery system transformation. It seems curious in light of the comprehensiveness and inclusivity of this report that the mental health system is referred to as beholden to a "historically distinct group of stakeholders". While this is undoubtedly true it bespeaks yet another barrier preventing the integration of behavioral health with general medical care. In the opinion of these authors the behavioral health of the population is within the province of public health.

Our findings support the direction the state is taking in its 1115 Demonstration Waiver Application to the federal government and, hopefully, provides additional context and outlines specific directions to achieve the transformation the state is seeking. The New Hampshire Department of Health and Human Services concept paper "Building Capacity for Transformation" outlines four steps to healthcare reform in New Hampshire:

Medicaid Transformation – *Serving the whole person through enhanced, cross-systemic care coordination*. The state proposes to improve care for vulnerable populations through the integration of, and access to, needed services. Special mention is given to the inclusion of both mental health and substance abuse treatment services within the scope of this transformation. The strategies presented in this report will move the providers in the state towards increased integration, will reduce the fragmentation of care and will improve access to behavioral health care. Blending behavioral health into primary care teams will increase the detection of, and the intervention for, persons with behavioral health issues. Payment reform will drive the necessary practice transformation

Expanded Health Coverage – *Expanding access to health care and improving the health status for those newly insured*. Extending coverage to previously uninsured individuals will likely increase the demand for healthcare services. It is important that new dollars support efficient and effective care models and current barriers to access are reduced. It will be especially important to meet high risk, complex patients with a care model equipped to address the complexity they present

Population Health – *Fostering public health integration and focusing on prevention for at-risk populations*. The State plan to improve the health of the population is charted in the recent release by

DHHS of the State Health Improvement Plan. Improvement in all ten focal areas of the plan is dependent, to a greater or lesser extent, on the health habits of the citizens of the State. The State intends to "promote coordination and collaboration among providers." Blending behaviorists into primary care, the front door to the healthcare system, facilitates this coordination and collaboration and brings an additional resource focused on the monitoring of, and promotion of, good health habits.

Mental Health System Reform –*Increasing access to and capacity for community-based services to support recovery*. The state acknowledges the need to restructure how mental health and substance use disorder treatment are delivered and recognizes the need to better integrate the services with medical care. The current mental health system is described as "disjointed in terms of the services it provides" and funding streams to the system are "misaligned." The concept paper further notes the long wait times for services and the crushing demand that exist with so many awaiting care. In our opinion capacity building may help to a certain extent but clearly new paradigms of service delivery are necessary in order to address the behavioral health treatment needs of the New Hampshire population. This report provides the blueprint for that transformation.

Summary

In summary, there is tremendous potential in the state of New Hampshire for real healthcare reform. There is leadership from the highest levels of state government, support from the payers, and commitment on the part of the providers to transform the delivery system in order to improve health outcomes and hold down costs. There is widespread interest in integrated care and the belief on the part of many that this approach to care will help achieve the Triple Aim Goals of improving health outcomes, enhancing access and lowering costs. Almost every primary care site we contacted is already engaged in some level of behavioral health and if the environment allows, these organizations are willing to expand integrated practice. Many of the community mental health centers are ready to partner in this endeavor by provide services to people who are best served in more specialized care and to assuring their patients receive primary care. Strong leadership will be necessary at many levels to bring about a common vision of integrated and collaborative services, thereby abolishing historic silos of care. Based on what we have observed we believe it will happen. With many promising initiatives already under way, it is not a reach to suggest New Hampshire has the opportunity to be an innovator in state-wide integrated care and a leader among the states in improving overall population health and controlling healthcare costs

Acknowledgement

None of this would be possible without the vision of the New Hampshire Endowment for Health and its unyielding concern for the health and wellness of the states' citizens, particularly the vulnerable and underserved. The Endowment is to be congratulated for its leadership of this study and the interest it has gained during the process. It should be noted that in several states where Cherokee Health Systems has worked and impacted state and/or payer policy to some degree, it has always been initiated by the advocacy and relentless support of a Foundation or Endowment. When concerned and engaged people join in a common vision to address seemingly insurmountable challenges, it is often amazing at what can be accomplished.

"A small group of thoughtful people could change the world. Indeed, it's the only that ever has."
Margaret Mead

APPENDIX A

Institute for Healthcare Improvement
Triple Aim Measures

Dimension	Measure
Population Health	1. Health/Functional Status: single-question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol)
	2. Risk Status: composite health risk appraisal (HRA) score
	3. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions; summary of predictive model scores
	4. Mortality: life expectancy; years of potential life lost; standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/*
Patient Experience	1. Standard questions from patient surveys, for example: -Global questions from US CAHPS or How's Your Health surveys -Experience questions from NHS World Class Commissioning or CareQuality Commission -Likelihood to recommend
	2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered)
Per Capita Cost	1. Total cost per member of the population per month
	2. Hospital and ED utilization rate

Steifel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2012.

APPENDIX B

Cherokee Health Systems	Domains				
Level of Integration Score	**0**	**1**	**2**	**3**	**4**
Defining Clauses [1]	**None - Precontemplation**	**Preferred Referral - Initial Stage**	**Colocation - Bidirectional Approach**	**Enhanced Colocaton**	**Fully Integrated**
1.A. A practice team tailored to the needs of each patient and situation *With a suitable range of behavioral health and primary care expertise and role functions available to draw from; with patients considered part of the team, and that specific team members are indentified and organized as a team to help patients achieve functional and/or disease goals.*	None to little; siloed care. Traditional Primary Care setting with no mental health/specialty care offered onsite.	May have an agreement or relationship with a speciality care organization to accept referrals, or "work them in" based on need.	May have a specialty BH care provider on site FT or PT that provides traditional care based on referral; maybe in a bidirectional approach.	May have a specialty BH care provider on site FT/PT that provides traditional and some in-room sessions for patients in PC; focused on mental health issues	Specially skilled behaviorist embedded FT/PT on PC team that serves the PC population through brief interventions.
1.B. With shared operations, workflows, and practice culture. *Shared phsyical space (co-location); Shared workflows, protocols, and office processes that enable collaboration; A shared practice culture rather than separate and conflicting BH and PC cultures.*	None to little. No interaction at all with specialty care.	None to little; may have contacts established on each side to enable patient access.	May share a facility, but have little formal interaction; referrals exchanged in traditional manner; may be in a bidirectional approach.	Shares a facility, including some support staff and waiting rooms. May participate in team meetings; care remains traditional and referral based.	Specially skilled behaviorists embedded in primary care; shared space; team meetings; work/patient flows established.
1.C. Having had formal or on-the-job training in preparation for the clinical roles of integrated care…	None to little. No interaction at all with specialty care.	None to little; may have knowledge of services offered at partner organization.	May have offered trainings on the role of the BH specialist and how and when to refer.	Providers may have received some training on integrated care and use appropriate terminology and practice "warm handoffs," but still offer traditional mental health care.	Specially skilled behaviorists are embedded in primary care and have received formal training from a reputable institution on brief interventions and primary care presentations.
2. With a shared population and mission (a panel of patients of patients in common for total health outcomes).	None to little; siloed care. Traditional Primary Care setting with no mental health/specialty care offered onsite.	May have an agreement or relationship with a speciality care organization to accept referrals, or "work them in" based on need.	May have a specialty BH care provider on site FT or PT (in PC/MH or both) that may accept referrals from PC, but maintains a traditional MH caseload as well that may or may not receive PC from the clinic.	Has a specialty BH care provider on site FT or PT that is available to accept referrals from the PC population; focuses mainly on traditional care, but may help with smoking cessation, etc.	Specially skilled behaviorist that is embedded on the PC team that sees the population of the PC clinic.

3. Using a systematic clinical approach (and a system that enables the clinical approach to function) *Employing methods to identify those members of the population who need or may benefit; Engaging patients and families in ID'ing their needs for care and the particular clinicians to provide it; Involving both patients and clinicians in decision-making; Using an explicit, unified, and shared care plan; With the unified care plan and manner of support to patient and family in a shared electronic health record; With systematic follow-up and adjustment of treatment plans if patients are not improving as expected.*	None to little; siloed care.	None to little; may have referral processes in place to enable patient access, and agreements to share information including treatment goals and medication information.	May have screening tools to ID depression, anxiety or other disorders. Documentation of specialty services may or may not be in the same medical record (EMR or paper), but is segregated. In a bidirectional approach, the organization screens for health/chronic disease issues.	Uses screening tools to ID depression, anxiety and SA issues. May have processes by which a MH specialist is activated to meet with the patient in PC; is still likely to be referred to a traditional service. Documentation may be completed in the PC EMR, but is likely to be traditional-based.	Screening for depression, stress, suicidal ideation and SA is standard practice; behaviorist easily activated by PC team when needed for brief intervention/screening. Documentation is completed in a shared record as part of the PC EMR; nothing is segregated.
4. Supported by a community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care.	None to little. No interaction at all with specialty care.	Providers recognize the need and refer for access to specialty care, but none is available in the clinic.	Specialty BH care is available within the confines of the clinic via referral; but it is still thought of as an adjunct to primary care (or adjunct to MH if in a bidirectional approach).	Providers recognize the benefits of behavioral interventions in primary care, but it is relegated mainly to traditional mental health presentations.	Providers recognize the benefits of behavioral interventions in primary care and routinely engage behaviorists in cases involving mental health, prevention, and health management. Culture reflects a seamless relationship.
5. Supported by office practice, leadership alignment, and business model: *Clinical operational systems and processes; Alignment of purposes, incentives, leadership; A sustainable business model.*	None to little. No recognition of system alliance or integrated practice.	Little to no leadership on integration; may have an agreement with a community provider for enabling access. No business model.	Leadership recognizes potential of collaboration; but lack of sustainable business modeling prevents expansion. Mission, values, purposes remain misaligned.	Leadership recognizes potential of collaboration; may use grant funds to support some semlence of integrated interactions and training. Long term sustainability remains a question.	Leadership values an intergrated model and has designed operations and business models to reflect the population-based approach. Aligned mission, values and purpose drive the patient-centered medical home practice.
6. Supported by a continuous quality improvement and measurement of effectiveness that: *routinely collects and uses practice-based data; And periodically examines and reports outcomes.*	None to little.	Organization may collect data on number of referrals and wait times for appointments.	Organization tracks number of referrals, wait times for appointments, and if it does any screening it may track prevalence of certain indicators.	Organization tracks number of referrals, wait times for appointments, screening results, and uses the data to enhance staffing.	Organization uses a robust EMR system to track a mileau of outcomes and data that is used to enhance workflow, patient services, and patient/provider
[1] Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Inegration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013.					

Definitions

1115 Waiver	A Federal act that grants states the authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.
ABD	Aged, Blind, and Disabled
AHRQ	Agency for Healthcare Research and Quality
Behavioral Health	Includes mental health, disease management, prevention, and substance abuse treatment.
Behaviorist	A specially trained and uniquely skilled clinical professional that is embedded on a primary care team; also referred to as a Behavioral Health Consultant. Is often a clinical psychologist or licensed social worker.
BHC	Behavioral Health Consultant
CHC	Community Health Center
CMHC	Community Mental Health Center
CPT	Current Procedural Terminology; a medical code set maintained by the American Medical Association.
CPT 96150-96155 Codes	A CPT code set that includes assessment of psychological, behavioral, emotional, cognitive, and relevant social factors that can help to prevent, treat, or manage physical health problems.
E&M Codes	Evaluation and Management codes
FQHC	Federally Qualified Health Center
HEDIS	Health Effectiveness Data and Information Set
HIE	Health Information Exchange
HRSA	Health Resources and Services Administration
IC	Integrated Care
MLR	Medical Loss Ratio
PBHI or PBHIC	Primary Behavioral Health Integrated Care
PMPM	Per member, per month
RHC	Rural Health Center
SA	Substance Abuse
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
Traditional Mental Health	When referenced in this report, “traditional mental health” refers to mental health services most reflective of those received in community mental health centers; for example: intensive individual therapy, group therapy, intensive outpatient programming for substance abuse, etc. These are services that tend to be highly structured, long-term in

	occurrence, and typically at least 45-60 minutes per session.
Triple Aim	A framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It simultaneously pursues three dimensions: Improving the patient experience of care, improving health of populations, and reducing per capita cost of health care.