



## **Integrating Primary Care and Behavioral Health *Ad Hoc* Meeting**

Friday, October 2<sup>nd</sup> 2015 - 1:00 p.m. – 3:30 p.m.  
Marshall University Graduate College – South Charleston Campus – Room 116

### **MEETING SUMMARY NOTES**

#### **Today's Expected Results:**

- Strengthen working relationships among key stakeholders
- Discuss successful primary care / behavioral health integration models
- Discuss the strengths, barriers and opportunities that exist for primary care and behavioral health integration in West Virginia
- Identify the essential elements needed for integration of primary care and behavioral health in West Virginia

**Meeting Planners:** David Campbell and Joshua Austin

**Facilitator:** Bruce Decker

**Participants:** 24 people – 24 in person; electronic participation was not made available

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
<b>Welcome, Introductions and Opening Remarks</b>	The Integrating Primary Care and Behavioral Health meeting opened with welcoming remarks, a review of the agenda, a discussion of the expected results along with a review of ground rules. Self-introductions followed.
<b>Integrating Primary Care and Behavioral Health Presentation</b>	Garrett E. Moran, Ph.D., Project Director for The Academy for Integrating Behavioral Health and Primary Care, provided an informative PowerPoint presentation on successful integration models from the states of Colorado, Missouri and Washington. Brief Q&A followed the presentation.
<b>Strengths, Barriers and Opportunities for Primary Care and Behavioral Health Integration in West Virginia</b>	<p>In small groups, participants discussed questions related to the strengths, barriers and opportunities for primary care and behavioral health integration in West Virginia. Small group discussion guidelines were provided to help direct participant interaction. These small groups provided a brief report to all meeting attendees.</p> <p><b>The responses below have been lightly edited for clarity.</b></p> <p>As identified in the West Virginia Primary Care Association whitepaper – <i>3 Key Components of the Health Center Model of Care</i>, there are six current barriers to behavioral health integration:</p> <ul style="list-style-type: none"> <li>• # Currently, health centers are unable to bill Medicaid for Master’s prepared psychologists, LPCs, LCSWs and LGSWs. The proposed changes to the BMS billing manual (currently posted for public comment on BMS website) will make a significant difference in the ability of health centers to increase access to care.</li> <li>• # Prior authorization requirements for brief intervention during a primary care visit are unnecessary due to the physician’s identification that a BH consult is needed.</li> <li>• Recruitment of behavioral health providers continues to be extremely challenging in West Virginia, especially BH providers who care for children.</li> <li>• Current WV law regarding the privacy of psychotherapy notes is more restrictive than the federal HIPAA guidelines. There is not a consistent methodology used within the state regarding the storage of psychotherapy notes. Some organizations maintain a confidential section within their EHR to store behavioral health psychotherapy notes, creating a barrier between primary care and behavioral health provider’s ability to care for the patient.</li> <li>• There is not a strong working relationship between many of the community mental health centers and the community health centers.</li> <li>• # Community health centers cannot serve as the originating and distant site for telehealth and are not</li> </ul>

authorized to serve as distant sites for telehealth consultations, which is the location of the practitioner, and may not bill or include the cost of a visit on the cost report.

**# Denotes a regulatory / policy or legislative change would be required.**

1. *Are there additional barriers to primary care and behavioral health integration other than those listed on the previous page and above?*

- Specific training for (to support) integrated care provision – cultivating a workforce
- Policy: payment structure that is outcomes-based
- Break down professional and personal silos
- LPCs can bill in FQHCs for Medicaid; is this possible with other payors?
- Care coordination payment model
- Defining care coordination role
- Prior authorization could be removed if payors agree and align on a screening tool
- Psychotherapy notes: sharing among primary care and behavioral health; state laws / regulations are more restrictive than federal laws / regulations – requires a legislative change
- Telehealth payment methodology: payors could define and agree on this topic

2. *Identify any barriers that require a regulatory / policy or legislative change. If known, identify the entity that would need to make the change (e.g., HRSA, CMS, WV DHHR, WV Legislature, etc.).*

- No responses identified specifically for this question

3. *What do you suggest as specific strategies to overcome or change barriers that do not require a regulatory / policy or legislative change?*

- Establish and re-build trust and relationships among payors – providers and among different types of providers (e.g., primary care and behavioral health)
- Share information and ideas
- Clarification / review of parity issues for behavioral health provider types
- Move all Medicaid beneficiaries and payment to managed care

	<ul style="list-style-type: none"> <li>• Challenge of recruitment / retention of providers</li> <li>• Remove of telehealth barriers regarding payment and deployment – explore Project Echo for mental health</li> <li>• Address perceived barriers to electronic health records integration of primary care and behavioral health</li> <li>• Explore sharing / training of behavioral health providers among different types of organizations and provider-settings</li> <li>• Engage academic institutions in training students in integrated care</li> <li>• Need to allow SBIRT codes approved for payment</li> <li>• Improve collaboration for telehealth services – primary care centers do not need to be behavioral health specialists if there is a good model of fast, timely connection to behavioral health staff at comprehensive behavioral health centers</li> <li>• Definition of “mental health note:” how does this impact how we share information?</li> <li>• Believe different models will be needed throughout the state</li> </ul>
<p><b>Creating an Integrated Primary Care and Behavioral Health System in West Virginia</b></p>	<p>In small groups, participants discussed questions related to creating an integrated primary care and behavioral health system in West Virginia. Small group discussion guidelines were provided to help direct participant interaction. These small groups provided a brief report to all meeting attendees.</p> <p><b>The responses below have been lightly edited for clarity.</b></p> <ol style="list-style-type: none"> <li>1. <i>Consider the definition provided below by the U.S. Agency for Health Care Research and Quality, as well as the graphic of “The Four Quadrant Clinical Integration Model” on page two of The Revised Four Quadrant Clinical Integration Model document ...</i></li> </ol> <p><b>AHRQ Definition</b> Care resulting from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost effective approach to provide patient-centered care for a defined population. This care may address mental health, substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related, physical symptoms, and ineffective patterns of healthcare utilization.</p> <ol style="list-style-type: none"> <li>2. <i>What do you consider to be the essential elements of an integrated primary care and behavioral health system?</i></li> </ol>

- Whole person – person-centered care
  - Culture of putting patient first / services go to where the patient is
  - Shared space and resources – more effective and efficient
  - Practice teams of primary care / behavioral health will vary by diagnosis and condition
  - Clear on target population that can be served
  - Shared repository of information
  - Determine how to work together
  - Determine who serves as “point” – who is coordinating
  - Serious mental illness (SMI) and severe and persistent mentally ill (SPM) have unique needs
  - Patients have same baseline screenings of primary care and behavioral health issues regardless of where they enter the system
  - Mutual understanding and respect of each other’s role
  - Flexibility of schedules to meet the patient “now”
  - Definite set of measures to monitor
  - Mentorship of each other – primary care providers can teach / educate behavioral health staff and vice versa
  - Care coordination should occur at the primary care level, allowing flexibility between primary care and behavioral health providers
  - Sharing of EHRs
  - Inclusive of patient-centered medical homes elements, including access, patient engagement, etc.
3. *Given that more than two-thirds of West Virginia's FQHCs / primary care centers have some level of patient-centered medical home designation, how can we leverage that to better coordinate care between FQHCs / primary care center and behavioral health providers?*
- Need to optimize telehealth deployment, data integration and data sharing
  - Sharing information about collaborative model more broadly
  - Standardized clinical quality measures; determine where differences exist
  - Learn best practices from the bi-polar / Hepatitis C Medicaid health home project
  - PMPM and shared savings concentrated on high risk patients utilizing a comprehensive care model
  - Sharing of training and technical assistance resources available through WV Primary Care Association, WV Behavioral Health Care Providers Association, etc.

	<p>4. <i>How can we leverage care coordination to assist in primary care and behavioral health integration?</i></p> <ul style="list-style-type: none"> <li>• Open communication between providers and payers while keeping patient at the center</li> <li>• Ability to share / see all data</li> <li>• Need to pay for care coordination to better leverage it</li> <li>• Opportunity to collaborate better with managed care companies – they have care coordinators; need to get more information from them</li> <li>• Ongoing / periodic meetings of primary care providers, behavioral health providers and payors</li> <li>• Address social determinants of health</li> </ul>
<b>Next Steps</b>	<p>Participants were asked to identify next steps on index cards.</p> <p><b>The responses below have been lightly edited for clarity.</b></p> <ul style="list-style-type: none"> <li>• Next steps are very important to resolving issues; will ultimately require decisions on design elements</li> <li>• Less talk, more action!</li> <li>• Explore various integration models in-depth. Brief explanation of the more favored models being considered and hosting experts from those organizations.</li> <li>• Payors and providers need to continue to meet! Have to understand where we are both coming from.</li> <li>• Keep folks meeting and talking to build / rebuild relationships.</li> <li>• Consider behavioral health and behavioral health system as equal in language and planning for future meetings.</li> </ul>
<b>Parking Lot</b>	None

**Group Checkout (Lightly Edited for Clarity)**

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> <li>• Great network of representatives</li> <li>• Very focused</li> <li>• Excellent ideas</li> <li>• Enjoyed Dr. Moran’s comments</li> <li>• Key topic for conversation</li> <li>• Good discussion</li> <li>• Time management</li> <li>• Productive and well organized</li> <li>• Breakout groups</li> <li>• Changing the groups up from exercise to exercise</li> <li>• Mixing up group members</li> <li>• Limiting to two topics for breakout</li> <li>• Garrett Moran’s presentation</li> <li>• Overall organization</li> <li>• Appreciate Garrett Moran’s perspective</li> <li>• Good communication</li> <li>• Great job!</li> <li>• Decent job with sensitive and important topic</li> <li>• Like the general overall support for 4 Quadrants</li> <li>• Good group, good conversation</li> <li>• Right focus areas generally</li> </ul>	<ul style="list-style-type: none"> <li>• Friday afternoon time</li> <li>• Don’t do Friday afternoon</li> <li>• Too short on time</li> <li>• Need more time to get to points – not on Friday though</li> <li>• More time for breakout sessions / separate rooms because of noise</li> <li>• Not enough time provided to really dig into structure that is best</li> <li>• This is a good first step, but really need a process to dig deeper; process and time didn’t allow deep enough dive into topics</li> <li>• Could use more group time</li> <li>• Bringing groups together</li> <li>• Hot in room</li> <li>• Need more AC</li> <li>• More provider involvement as this progresses</li> <li>• Questions proposed to the group were too general</li> <li>• Expand variety of participants (e.g., representatives from WV Association of Physician Assistants, family medicine, etc.)</li> <li>• Too much “turf”</li> <li>• Change the order of the questions per group</li> <li>• Poor physician representation</li> </ul>