

**CYBHWG Behavioral Health Integration subgroup**

**Tuesday, June 29, 2021  
10:00 am – Noon**

Action Items – Use for Workforce and Rates notes; delete for CYBHWG meeting					
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status
1.	Sarah Kwaitkowski and Sarah Rafton and Kristin Houser talk about statewide approach to BH care.	Sarah Kwaitkowski			
2.	Sarah Rafton Interview Dr. Phyllis Cavens	Sarah Rafton			
3.	Mary-Stone Smith Interview BH providers	Mary			

Agenda Items	Lead
Agenda review	<p><b>Kristin Houser</b></p> <p>Key questions</p> <ul style="list-style-type: none"> <li>• How can we make this a reality for all kids?</li> <li>• What financing gap(s) need to be addressed?                             <ul style="list-style-type: none"> <li>• Start-up?</li> <li>• Sustaining?</li> <li>• Future VBP methodology to support BHI?</li> </ul> </li> <li>• Are laypeople / navigators an important component of supporting kids and families?</li> <li>• How can we increase equitable access to BHI?</li> <li>• Politically/financially realistic goals for 1 year?</li> </ul>
Pediatric integration at a Yakima Valley Farm Workers Clinic	<p><b>Thatcher Felt &amp; Philip Hawley, Yakima Valley Farm Workers Clinic</b></p> <p>See page 4 for slides.</p> <p>Highlights:</p> <ul style="list-style-type: none"> <li>• Primary care behavioral health model (PCBH).</li> <li>• Benefits: BH consultants (BHC) can see patients on the same day, don't have to make an appointment. BH consultants can provide bridge to clinicians (3-5 month wait).</li> <li>• For this group, would advocate for a focus on rates.</li> <li>• Goal: To improve access and to improve primary care, not to replace BH counseling.</li> </ul> <p>Discussion/Q&amp;A:</p> <ul style="list-style-type: none"> <li>• How long can BHCs meet with patients? Is goal to connect them to someone outside? Most people only see the BHC 1 or 2 times; a small number see them for longer periods of time. No hard cap. Some agencies BHCs see people an average of 4-6 times. Primary goal: Access. So, less clients seeing BHC for more visits, so more clients can be seen.</li> <li>• Generally, visits are 20-25 minutes; can be shorter or longer.</li> <li>• BHCs are masters or doctoral level.</li> <li>• Currently 90-95% of visits are in person.</li> <li>• Do satisfaction surveys annually – of patients and primary care providers.</li> </ul>

	<ul style="list-style-type: none"> <li>• Can bill BH codes as part of an FQHC, fee for service, grant funding, and contracts with Medicaid MCOs. Not revenue generating – commitment by the organization – can break even. We also see uninsured people and don't get paid for them.</li> <li>• Research indicates that 50-75% of primary care patients could have a BH component – might not rise to a diagnosis and be eligible for outpatient BH services but can address and bill in PC.</li> <li>• CHWs and BHCs both serve (different) navigator roles.</li> </ul>
<p>Commercial insurance and pediatric behavioral health integration</p>	<p><b>Sarah Kwiatkowski</b>, Premera Blue Cross  <i>See page 36 for slide deck.</i></p> <p>Highlights:</p> <ul style="list-style-type: none"> <li>• Can only collect premiums on covered services. See page x for required coverage in commercial plans.</li> <li>• For the most part, large group fully insured and self-funded group plans do cover BH, even though they are not required to. (Only requirements are around parity with physical care benefits).</li> <li>• Carriers want to be included in the decisions. What are the gaps? Getting the data, being able to address the gaps. We need state \$ to invest in the delivery system. It's not always going to be the carriers who can finance; partner with the state to leverage state dollars. Need to identify additional services that are not traditionally reimbursed in commercial insurance (like wrap around services) and determine how to cover. Premiums on covered services are meant to sustain the organization – office managers, administration etc.</li> <li>• Premera used investment funds to reinvest in communities – built clinics where services were not available.</li> <li>• Main focus on Medicaid; need to include commercial carriers – not at the table (Accountable Communities of Health). Not just asked for money; want to be true partners. "We are invested in these communities."</li> <li>• Some uncompensated care is because providers are hesitant to bill commercial insurers.</li> <li>• Premera – pilot program - Using a vendor on the back end that aggregates providers – using a third party administrator (TPA) to provide an insurance-blind system.</li> <li>• Integration – disparate approach from region to region – easier for commercial carriers if it was a more universal model.</li> </ul> <p>Discussion/Q&amp;A:</p> <ul style="list-style-type: none"> <li>• How long can BHC meet with patients? Is goal to connect them to someone outside?</li> <li>• Please bring us (commercial carriers) into the statewide conversation around integration – not an area that we've been invited to participate.</li> <li>• What should premium dollars be paying for, what works for young people?</li> </ul>
<p>Financing barriers/gaps in existing pediatric BH integration programs in primary care</p>	<p><b>Tatiana Sarkhosh</b>, Washington Chapter of the American Academy of Pediatrics  <i>See page 48 for slides.</i></p> <p>Highlights:</p> <ul style="list-style-type: none"> <li>• Independent clinics: Startup costs 2-3x normal costs; don't know what the true cost of the program will be.</li> <li>• Differences in minutes allowed and other things based on insurance carrier.</li> <li>• Lots in slide deck on non-billable costs.</li> <li>• Expressed need to include startup costs and non-billable BHI work in capitation.</li> <li>• Upcoming: BHI Financing Barriers report.</li> <li>• Presenting again in a month – unofficial report for this group.</li> </ul> <p>Discussion/Q&amp;A:</p>

	<ul style="list-style-type: none"> <li>• Some solutions that work in the Medicaid space won't work in the commercial space (and vice versa) because of regulations – input when considering solutions.</li> <li>• Significant number of people talked about the benefit of being able to talk / consult regularly with BH professionals.</li> </ul>
<p>Next steps, coming presentations, questions for consideration</p>	<ul style="list-style-type: none"> <li>• How can we make this a reality for all kids?</li> <li>• What financing gaps need to be address? Start-up? Sustaining? Future VBP methodologies to support BHI?</li> <li>• Are laypeople/navigators an important component?</li> <li>• How can we increase equitable access to BHI? <span style="float: right;"><i>See page 56 for edited Chat log.</i></span></li> </ul>

### Attendees

Marci Bloomquist  
 Rachel Burke, Health Care Authority-Division of Behavioral Health and Recovery (HCA-DBHR)  
 Dr. Phyllis Cavens, Child and Adolescent Clinic  
 Christine Cole, HCA-DBHR  
 Joe Contris, Community Health Plan of Washington (CHPW)  
 Kahlie Dufresne, Molina Healthcare  
 Rachel Dumanian, ChildHaven  
 Victoria Evans, Molina Healthcare  
 Thatcher Felt, Yakima Valley Farm Worker's Clinic  
 Silvia Gil, CHPW  
 Leslie Graham, UW Neighborhood Clinic, Kent-Des Moines  
 Kimberly Harris, HCA-DBHR  
 Phillip Hawley, Yakima Valley Farm Worker's Clinic  
 Libby Hein, Molina Healthcare  
 Robert Hilt, Seattle Children's/UW  
 Kristin Houser, Parent  
 Avreayl Jacobson, King County Behavioral Health and Recovery  
 Christine Kapral, CHPW

Sarah Kwiatkowski, Premera, Association of Washington Health Plans (AWHP)  
 Bridget Lecheile, Washington Association for Infant Mental Health (WA-AIMH)  
 Laurie Lippold, Partners for Our Children  
 Debbie Pineda, Child and Adolescent Clinic  
 Wendy Pringle, HopeSparks  
 Sarah Rafton, Washington Chapter of the American Academy of Pediatrics (WCAAP)  
 Shannon Re, Kitsap Children's Clinic  
 Caitlin Safford, Anthem and Amerigroup Washington  
 Tatiana Sarkhosh, WCAAP  
 Noah Seidel, Office of Developmental Disabilities Ombuds  
 Lucas Springstead, HCA-DBHR  
 Mary Stone-Smith, Catholic Community Services of Western Washington  
 Beth Tinker, HCA-Clinical Quality and Care Transformation  
 Amber Ulvenes, WCAAP and Kaiser Permanente  
 Liz Venuto, HCA-DBHR  
 Jackie Yee, Educational Service District (ESD) 113

# Yakima Valley Farm Workers Clinic

- One of the largest community health centers in the country
- 26 clinic sites WA and OR
- Underserved communities
  - Rural and urban*
- 90-95% Medicaid population
  - Pediatrics in Grandview*
- 16 clinics with on site behavioral health



# PCBH @ YVFWC

Red Text indicates current openings



# What is Behavioral Health Integration?

**Illustration: A family tree of related terms used in behavioral health and primary care integration**  
See glossary for details and additional definitions

## Integrated Care

Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Attitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

## Patient-Centered Care

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

## Coordinated Care

The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshaling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

## Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

## Collaborative Care

A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

## Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

## Integrated Primary Care or Primary Care Behavioral Health

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiser, 2007; Hunter et al, 2009).

## Behavioral Health Care

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

## Patient-Centered Medical Home

An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

## Mental Health Care

Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

## Substance Abuse Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

## Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

# Primary Care Behavioral Health (PCBH)

## Behavioral Health Consultant (BHC):

1. Share same clinic space as primary care
2. “Warm handoff”
3. Diversity of care
4. Able to see patients same day
5. Can follow with scheduled encounters
6. Bridge gap between BH referral
7. Share clinic charting with primary care
8. Direct communication with primary care

# 17y/o “Jose”

- Presented with severe anxiety
- Lives very rural >90min from clinic
- Junior failing all classes, not participated in remote learning for months
- Tachycardic, looked away, hardly audible, very brief answers to questions
- Globally positive SCARED anxiety screening scores
  
- Fluoxetine started
- Significant need of counseling



# 17y/o “Jose”

- Behavioral Health Consultant (BHC) able to see same day
- Transportation difficult, “Jose” sees BHC each primary care visit
- Virtual care – telehealth for anxiety management and counseling encounters
- Weekly appointments with BHC

## Outcomes:

- Mild improvements in anxiety. Lost to follow-up

# 15 day old “Katie”

- First Year Families – Washington Chapter of the American Academy of Pediatrics  
*Promotes Edinburgh maternal depression screening 2wk, 2mo, 4mo, 6mo WCC*
- Mom screened positive for maternal depression
- Maternal depression with previous child, grateful our clinic was screening  
*Concern shared with maternal primary care provider*
- Met with BHC x2

## Outcomes:

- Depression symptoms resolved
- Edinburgh screening negative subsequent WCC

# 8y/o “Mario”

- Significant behavior concerns home and school 2<sup>rd</sup> grade
- Hyperactivity, poor focus, “wiggly”. Fighting, irritability with siblings at home
- Conner forms – significant discrepancy between scores from two teachers
- BHC talks directly to teacher

Dx: Combined type ADHD, sibling conflict

# 12 y/o “Mario”

## Outcomes:

- Well managed with stimulants and guanfacine
- Seen q3mo for ADHD f/u appointments
- Deminished challenges with siblings, improved anger management
- Initially seen monthly by BHC
- BHC “touch point” with each ADHD f/u encounter
- Starting middle school this Fall with significant school improvement

# 3y/o “Peter”

- Routine WCC – anger and hitting siblings
- Mom seemed overwhelmed, 3 busy kids in exam room
- Parents managing behavior problems with spanking
- Many issues to address, limited PCP time
- BHC “warm handoff”, seen same day

## Outcomes:

- No spanking 4y/o WCC, improved sibling relationships

# 14y/o “Patricia”

- Hospital f/u for acetaminophen overdose
- Break up with boyfriend of 2 years, sister/best friend leaving house
- Remorseful, reserved. Impulsive act
- Seen by Crisis Management – discharged with outpatient mental health evaluation

## Outcome:

- Outpatient behavioral health not available 3-5 months in our area
- Seen by BHC same day
- Will f/u with BHC until outpatient behavioral health established

# Improving Behavioral Health Access in Rural Primary Care

Dr. Phillip Hawley, PsyD

Summer 2021





# Yakima Valley Farm Workers Clinic

we are *family*

- At Yakima Valley Farm Workers Clinics we utilize the primary care behavioral health model of integration. Behavioral Health Consultants (BHC) provide expert access in primary care to meet this primary care behavioral health needs.
- These children and families have many obstacles to accessing care including cost, limited availability of resources, transportation and stigma.
- With approximately 1,500 visits each year per BHC, we recognized the need to be innovative in the delivery and collaboration efforts to better meet the needs of our busy clinic and community.





# 2020 Total Numbers

- BHCs saw a total of 14,687 unique patients in 2020
- Population reach average across clinics was 12.17%
  - Range: 7.00%- 21.92%
- 17,867 BHC encounters
- +7,407 additional patient touches
  - These include telephone calls, EPIC documentation notes, care coordination, and PCP consultation w/o patient present visits.
- =25,274 total BHC patient touches

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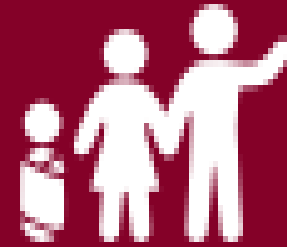
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# Patient Breakdown

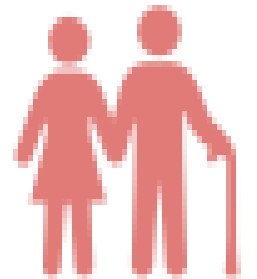
Org-wide close to  
50/50 split for  
adults and children



CHILDREN  
**46.8%**



ADULTS  
**46.7%**



SENIORS  
**6.5%**

# Percentage of Population by Age in Years Range



Between 1/1/2020 and 12/31/2020

19 years or more  
74.4 %

- BHC visits by Age:
- For 2020
- 9.6% of visits with Teenagers
- 3.7% for the 9-12 age range.
- 12.3% for patients less than 9

less than 9 years  
12.3 %

12 years - 19 years  
9.6 %

9 years - 12 years  
3.7 %

# 41.7%

of our patients had a primary language other than English



### Patient ethnicity

**64.1%** Hispanic/Latino  
**34.8%** Non-Hispanic/Latino  
**1.1%** Unreported/Refused

Patients served:

# 181,331

Patient encounters:

# 747,312



**50.1%** 100% or less  
**26.6%** 101 - 150%  
**12.7%** 151 - 200%  
**7.0%** > 200%

### Insurance coverage

**58.0%** Medicaid  
**17.6%** No Insurance/Uninsured  
**16.1%** Private Insurance  
**7.4%** Medicare  
**0.9%** Public Insurance



CHILDREN  
**46.8%**



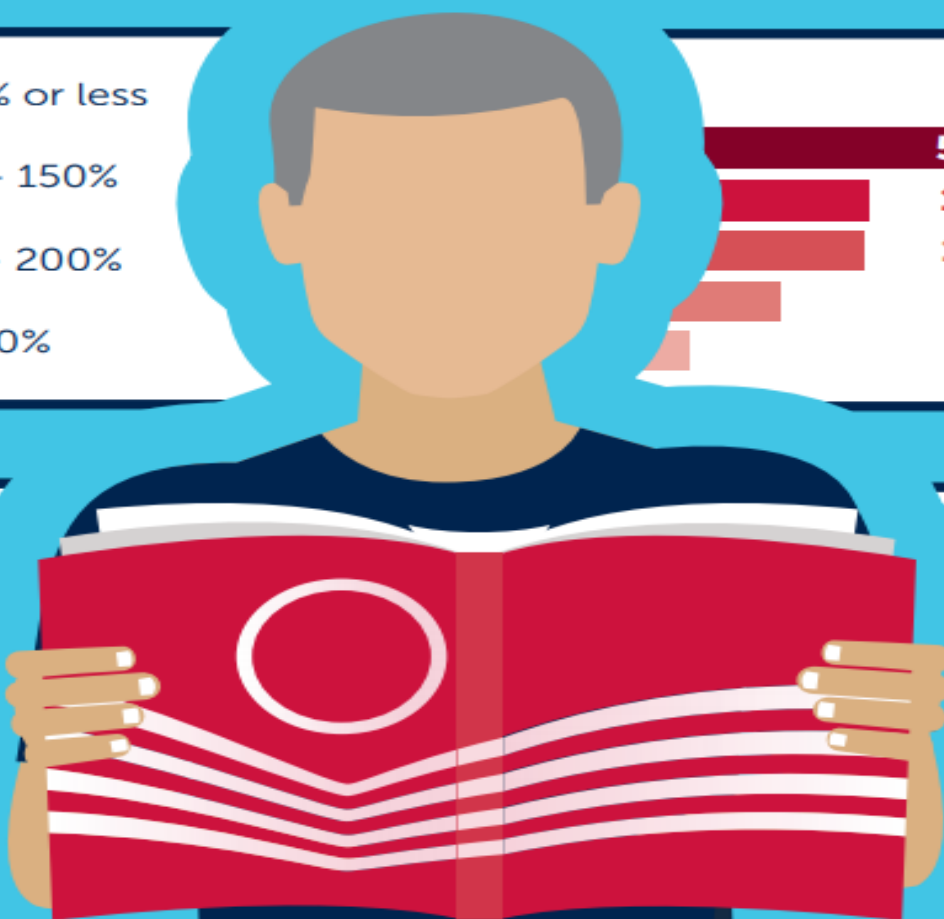
ADULTS  
**46.7%**



SENIORS  
**6.5%**

### Special populations

**23.6%** Seasonal  
**6.0%** Homeless  
**5.6%** Migrant  
**1.2%** Veterans



# Growing Need for Behavioral Health with Pediatric Patients

Limited access to mental health services in Washington State

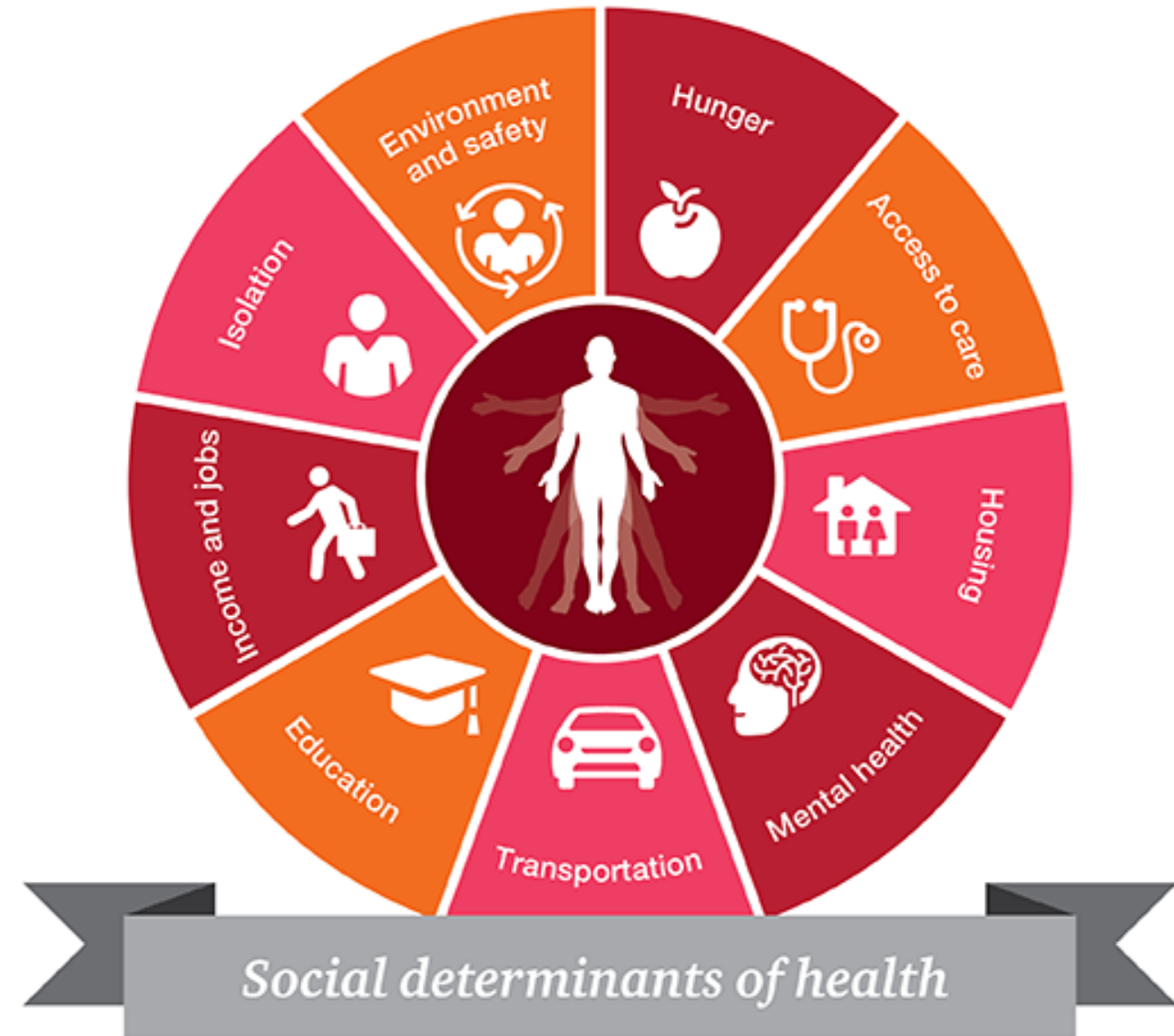
- Roughly 70,000 youth reported depressive episode in last year.
- Only 12,000 (24.5%) of youth with severe depression received consistent therapy services.
- 39,000 (61.7%) youth didn't receive any treatment for depression.
- In our rural community, community mental health agencies are overwhelmed with referrals for services, and children with ADHD only often are not seen due to the need to prioritize more severe referral conditions.



(Mental Health America, 2019)

# Need

- Clinic: Our healthcare system is dedicated to improving our patient's overall health, we have been paying particular interest to social determinants of health, specifically communities and education.



# Addressing Barriers to Care

- Technology is used in several ways to address these challenges
  - Tele-BHC visits
  - Mychart (patient portal)





# Tele-BHC

Using an iPad on a portable stand we can simulate an in-person consultation remotely

- Same day access
- Coverage across clinics and regions
- Privacy
- Real time consultation with primary care



Thank you for your visit to the clinic today. If you have any questions, we hope you will contact us via MyChart or by calling the clinic at 509-865-5600.

8/30/19 4:52 PM



Gracias por su visita a la clínica hoy. Si tiene alguna pregunta, esperamos que nos contacte por MyChart o llamando a la clínica al 509-865-5600.



When I was writing the letter about the person I was sad at first and then it started to get better, but at times it makes me sad knowing that there are not here with me.

9:05 AM

This is so great that you were able to do this. It can be hard to still miss this person. When we care about someone and they pass away we can feel sad for a long time. It is okay to feel sad about this, but we really want to make sure we are talking or writing about these feelings. I want you to write another letter next week and notice if you are feeling the same, or different. Keep up the great work. You are doing an awesome job!

11:42 AM



Phillip Hawley, PsyD



Okay

11:58 AM



I was wondering to become a counselor what do I have to do in college or in other things.

11:06 AM

# REACH



# REACH

**2 months of community-based experiences**

**Toppenish, WA** experiential and service-based learning about community partnership, and assessing and responding to community health needs and assets



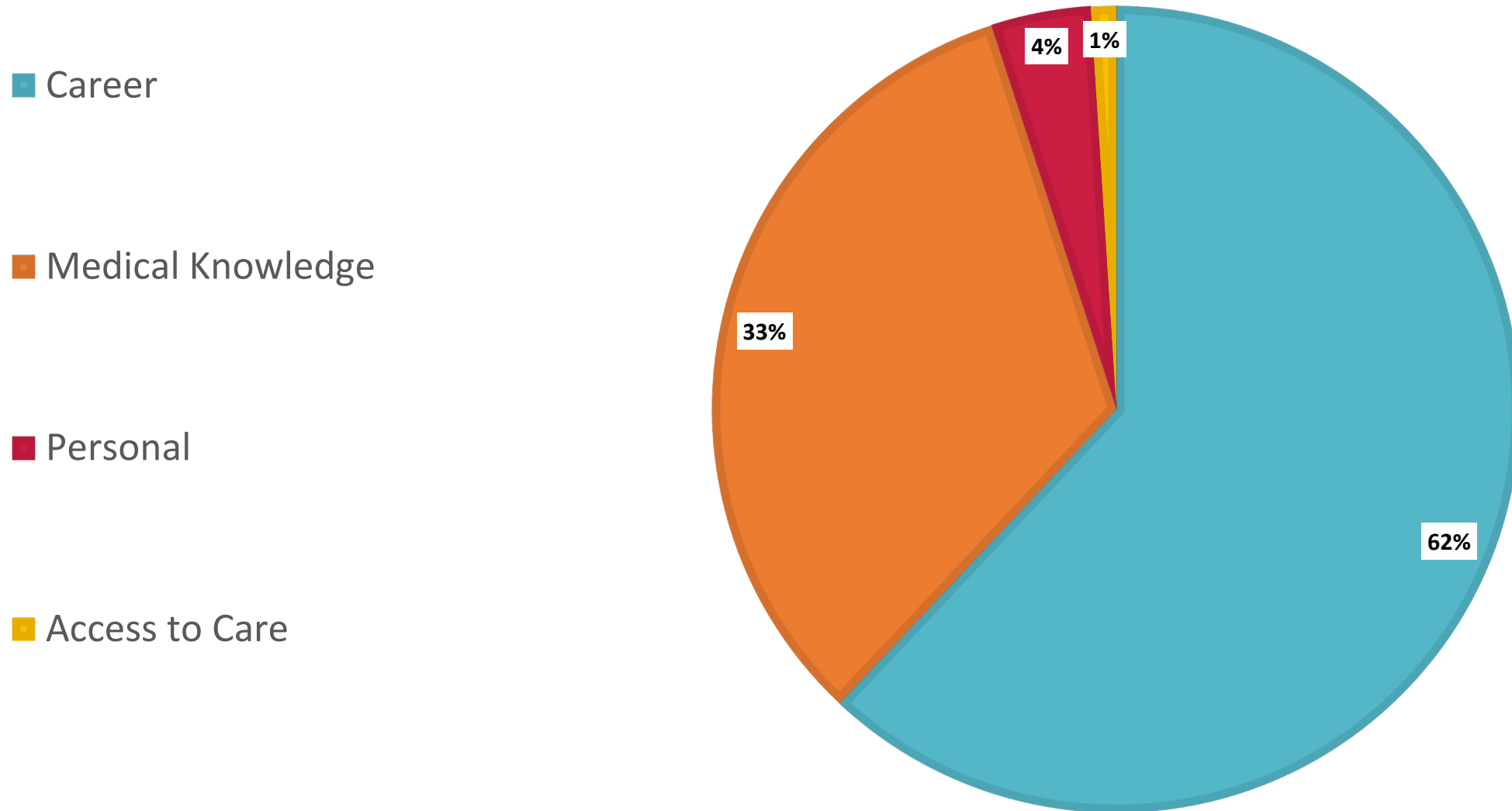
# REACH

- Ask a Doc sessions
- REACH residents go to school classrooms and answer health and career questions submitted by students
- Multiple sessions in TMS, THS and Tribal School historically, most recently most at THS



# REACH

## QUESTION TYPES

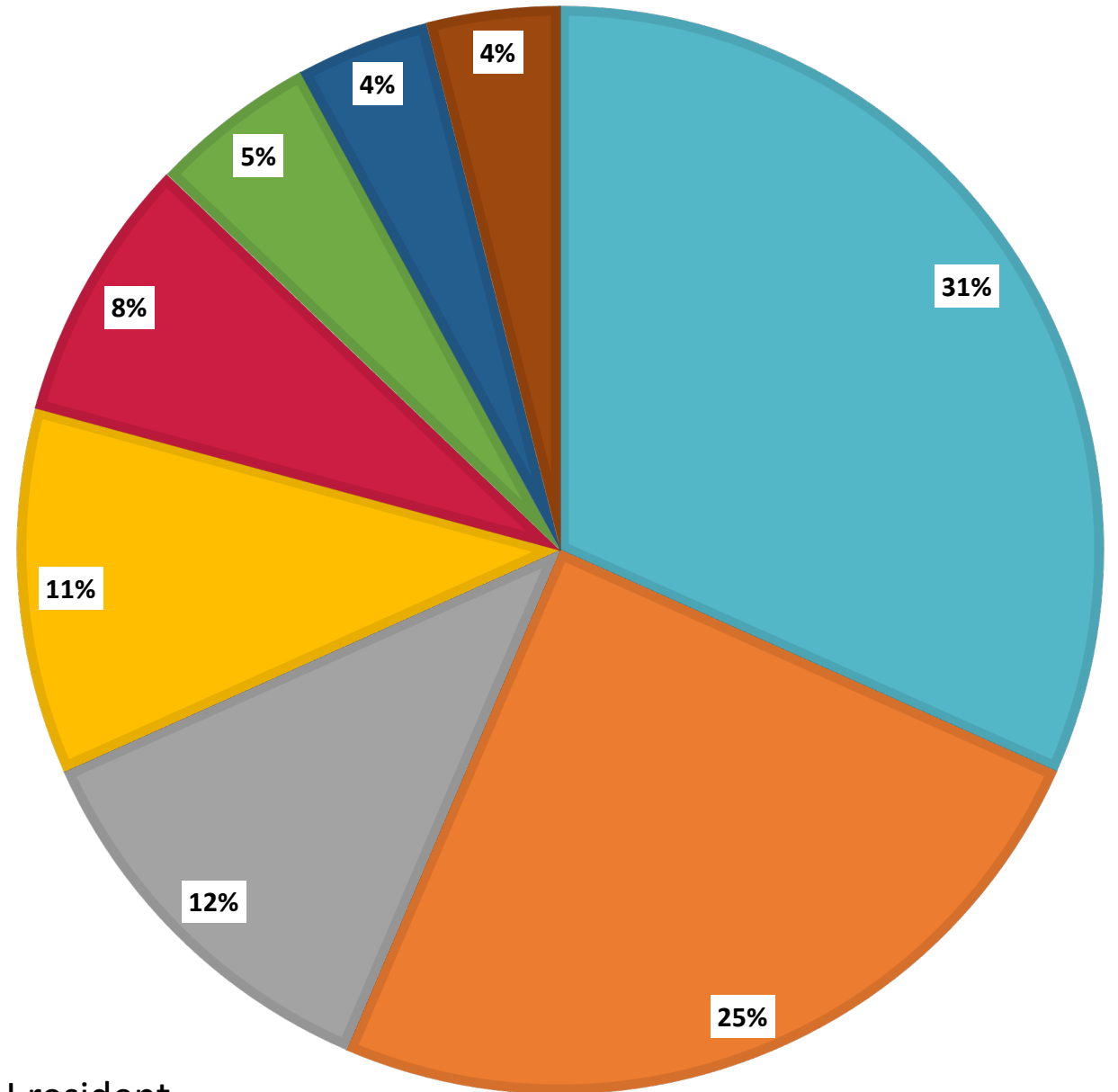


Data from Dr. Kathryn Bailey, former REACH resident

# REACH

## MEDICAL KNOWLEDGE QUESTIONS

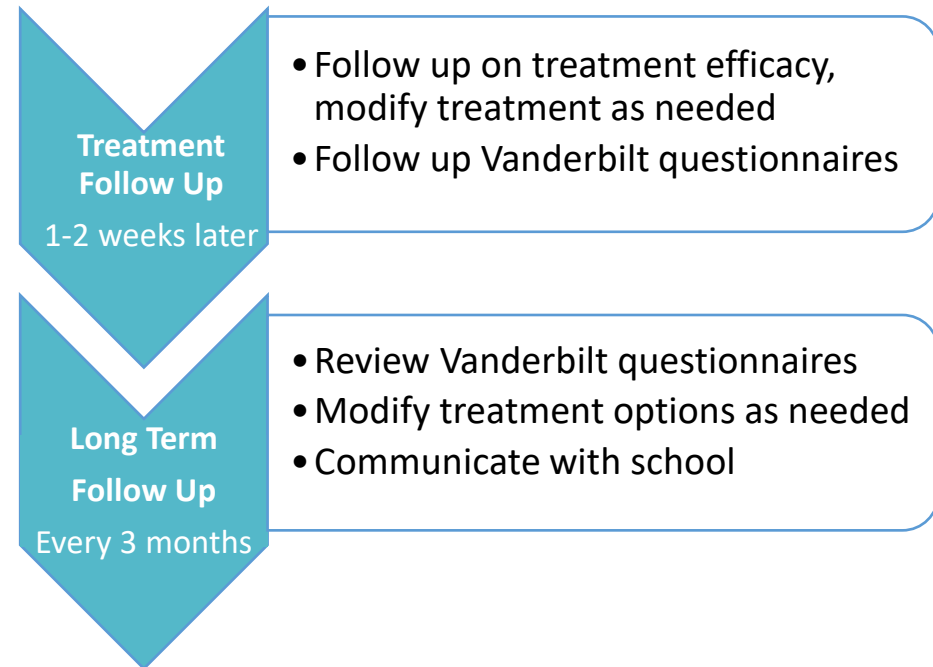
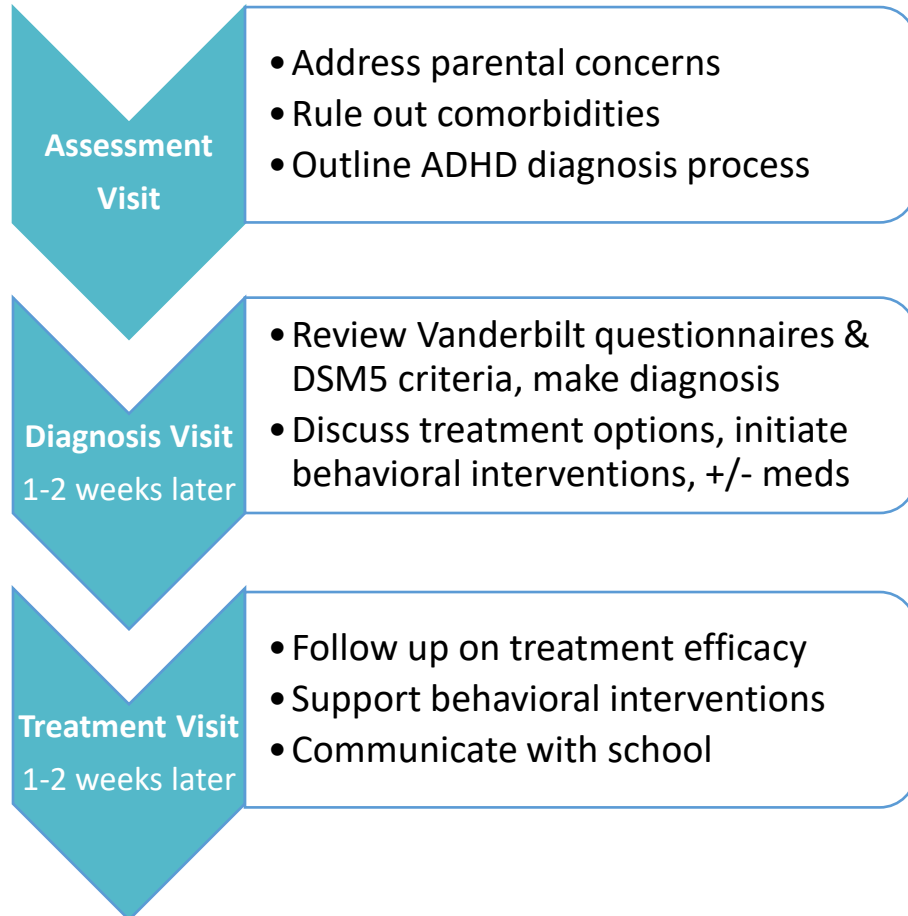
- Sexual Health
- General
- Mental and Behavioral Health
- Wellness
- Musculoskeletal
- Toxicology
- Cost of Care
- Diabetes



Data from Dr. Kathryn Bailey, former REACH resident

# ADHD Visits:

## Primary Care Provider & Behavioral Consultant



**PCP visit: 20 minutes**  
**BHC visit: 15 minutes**



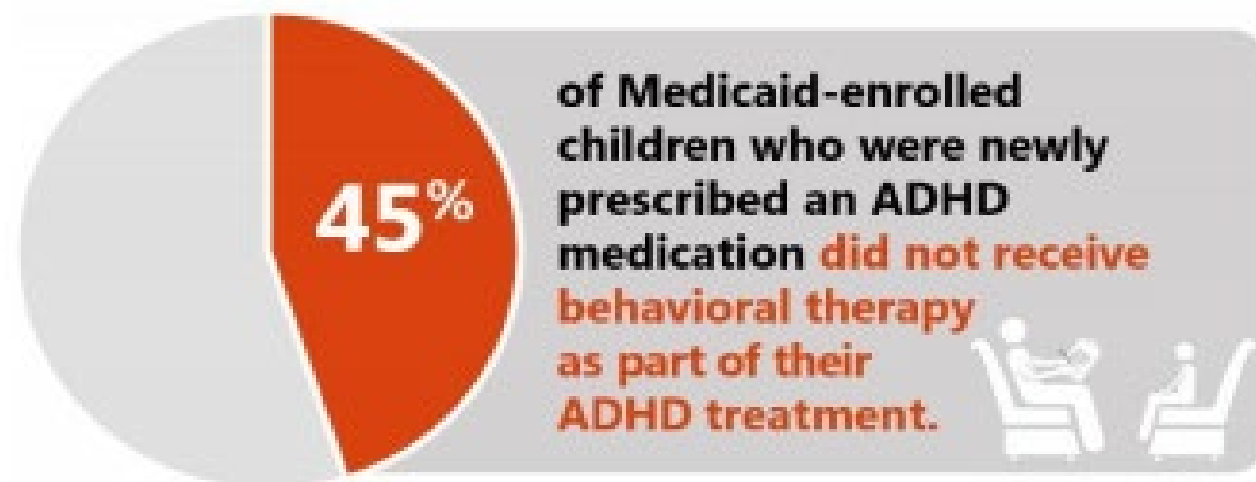
# Challenges to appropriate follow-up care for ADHD



- Limited access to appointments with primary care providers
- Lack of behavioral health practitioners
- Lack specialized training in diagnosing and treating ADHD
- Evidence-based services may not exist in every community
- Some parents of children with ADHD are also diagnosed with ADHD

# Challenges to follow-up care for ADHD

- 873,833 children with Medicaid were newly prescribed an ADHD medication
- 59% did not receive follow up care within 30 days
- Not meeting national quality measures



US Department of Health and Human Services Office of Inspector General Report August 2019

# Questions/ Discussion



we are family

# Commercial Carrier Perspective – Behavioral Health Integration

Sarah Kwiatkowski, Premera Blue Cross

Association of Washington Health Plans, Commercial Carrier Representative

June 29, 2021

Let's level set –  
what are we  
talking about  
when we say  
“commercial”

# What is commercial insurance?

- **Self-Funded employer plans**

- Large employers
- Employer as the risk
- Benefits and coverage governed by federal requirements, not state

Regulated by federal government (ERISA law and other federal laws)

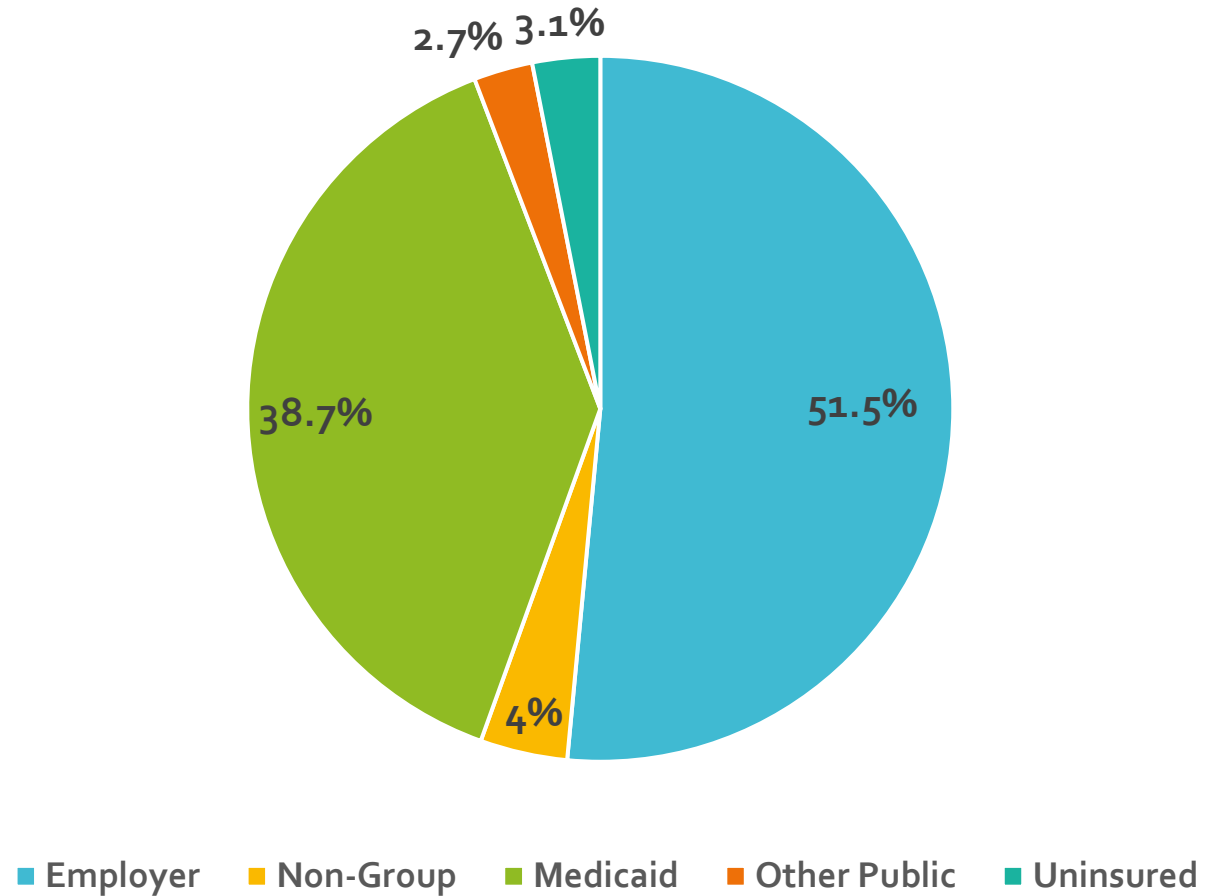
- **Fully Insured plans**

- Individual plans (on & off Exchange)
- Small group employer plans
- Large group employer plans (+50 employees)

Regulated by the state

Approximately 50% of the state's young people & children are covered by employer-based insurance

Health Insurance Coverage of Children 0-18 (2019)\*



\*Source: Kaiser Family Foundation, State Health Facts, accessed here: <https://www.kff.org/other/state-indicator/children-o-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

## Who are the commercial carriers in our state?

- Aetna
- Asuris Northwest Health
- Cigna
- Community Health Network of Washington
- Coordinated Care
- Bridgespan
- Kaiser Foundation Health Plan of Washington
- Kaiser Foundation Health Plan of the NW
- Kaiser Permanente
- LifeWise
- Molina
- PacificSource Health Plan
- Premera Blue Cross
- Providence Health Plan
- Regence BlueShield of Oregon
- Regence BlueShield
- United Health Care

## Level set: benefits & coverage

### Fully insured small group and Individual market plans

- **Essential Health Benefits**
  - Includes both mental health & substance use disorder services
  - States set the “benchmark” for the EHB.
  - WA’s benchmark can be found [here](#).
- Health plans may design different plan designs and benefit structures, including cost-sharing, virtual provider access, and other designs
- Mental Health Parity Applies

### Fully insured large group & Self-funded group plans

- EHB requirement does *not* apply
- **Federal Mental Health Parity law** does apply
  - MHPAEA does not require large group health plans or health insurance issuers to cover MH/SUD benefits
  - Requires general equivalence in the way MH/SUD and Med/Surg benefits are treated
- **WA law** – fully insured large group
  - [RCW 48.44.240](#) – chemical dependency
  - [RCW 48.44.341](#) – mental health services
  - [RCW 48.43.093](#) – emergency services, includes MH/SUD

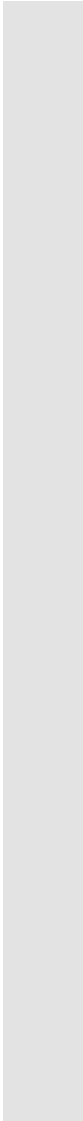





# Partnerships



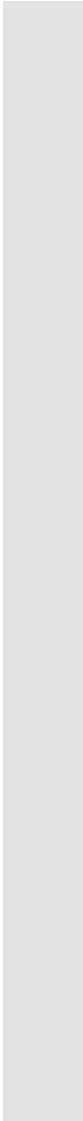

# Financing gaps



# Challenges / Barriers from the Carrier Perspective

## Identified Barriers:

- Behavioral Health Integration (BHI) for young people and children is disparate across the state; a statewide, consistent approach would help
- Access to data
- Workforce
  - Not understanding commercial insurance
  - Adapting to serve commercial members – there needs to be state support to help providers/agencies through transition
  - We don't know the level of integration across our networks
- Billing and claims
  - Variation across payers
  - Limitation of what can be reimbursed for services provided by non-physicians
- Lack of engagement by ACHs and others in bring commercial carriers into the transformation efforts



Where should the focus  
be for 2022?

## Next Steps for BHI in the commercial space

- Next steps to bring commercial carriers into the statewide efforts on BHI efforts
- Increasing access to data reporting on the outcomes and costs of behavioral health integration in pediatrics
- Study of and recommendations of the continuum of BHI in pediatrics that outlines how different models may benefit and improve outcomes based on age and acuity

# Questions?

Contact information: Sarah Kwiatkowski,  
[sarah.kwiatkowski@premera.com](mailto:sarah.kwiatkowski@premera.com)

# Behavioral Health Integration Financing Barriers

June 2021





# BHI Interviews

- May – June 2021
- 6 interviewees with primary care providers/administrators and BH center providers/administrators
- Discuss key categories of financing barriers to BHI in primary care settings for kids
  - Startup
  - Training
  - Billing/codes
  - Physical space
  - Care coordination
  - Data management
  - Cost-saving

# Barrier #1: Start up costs

- Difficult for independent clinics to finance without grant funding
  - Most practices won't know the true cost of the program
- Training all staff on the model
- Learning best practices
- Therapist credentialing/certification process is very lengthy
- For practices that partner with BHOs, building or allocating space for their staff
- Recruitment, hiring, training
- Investing in technology
  - Cross-communication with other EHR
  - Registry or tracking system
  - Integrating codes

# Barrier #2: Billing/Codes

- Fee for service billing is not sustainable for BHI programs
  - Losing money or breaking even
- Want to maintain flexibility and creativity of BHI, not just co-located care. Ensuring this means uncompensated time for essential components of BHI for kids:
  - Block time during the day to respond to emergent needs
  - Warm handoffs
  - Brief counseling
  - Expand services to include group therapy, postpartum care, substance abuse, support groups, etc.
- Limitations on the insurance types that can participate

# Barrier #3: Non-billable “soft costs”

- Spending time together
  - Often integrating two different organizational cultures
  - MD and BH staff meetings
- Care coordination
  - Separating patients into care “buckets”
  - Reminders
- Preparing for a patient during warm handoff
- Meeting with psychiatric consultants
  - All MD staff, therapist(s)

# Barrier #4: Demonstrating Value

- Collecting, monitoring, and managing data
- Demonstrating cost-savings
  - Diverting from emergency department
  - Maximizing clinicians working at the top of their license
  - Promoting a healthy workforce
- Demonstrating value is a specific skill set
  - Can lead to additional funding
  - Not reimbursed

# Final thoughts

- Value Based Payment
  - Start up costs
  - Include non-billable BHI work and ongoing administrative costs in capitation
- Competitive recruitment
  - Specific skill set and desire to work in clinical setting
  - Challenge for rural clinics
  - Support during credentialing/certification process
  - Bilingual staff
- Investing in BHI-support staff will lead to cost savings
  - Increased productivity
  - Minimize burnout
  - Reduce turnover

# Questions?

- Contact Tatiana Sarkhosh at [tsarkhosh@wcaap.org](mailto:tsarkhosh@wcaap.org) to contribute to the BHI program financing barriers report.

## 6-29-21 Behavioral Health Integration Subgroup Chat Log

### Pediatric integration at a Yakima Valley Farm Workers clinic

- Is the behavioral health consultant (BHC) an employee of the clinic?  
*Yes.*
- Thank you for sharing! Can you tell us a little bit more about the credentials/qualifications of a BHC to address the diversity of care they are providing? What kinds of professionals do you hire for this role?  
*In our system BHC is primarily psychologists and LCSW.*
- Phillip, I love the point that you made about how PCP or medical home is "ongoing". Episodes of care can take place with brief interventions and can open and close but overall, integrated care just that. Thanks for a great presentation.
- It would be helpful to me as Tatiana Sarkhosh at WCAAP to better understand FQHC financing and why / how it seems to make BH integration more viable. Any ideas of who can help us understand this?  
*Bob Marsali might be good to connect with Sarah. I imagine this is because of the encounter rate FQs and RHCs get but Bob and his Assoc would probably be able to provide you a good perspective.*
- My understanding is FQHC funding is similar to nursing home funding. FQHCs submit the actual costs for their services. There used to be about an 18 month lag between data submission and change in payment rates. So current rates paid are based on previously submitted data. Part of what is so helpful for this funding approach is funding more closely aligns with costs.
- I don't think pediatric clinics can become FQHCs, unfortunately. I think they have to serve all ages.

### Financing barriers

- It sure sounds like there are common threads in terms of barriers and limitations in both worlds. Thank you for your presentation and for being so straightforward about the need for us to engage with the commercially insured system.
- I am hearing consistent messaging that there are components of BH services that are not billable, whether Medicaid or Commercial Insurance.
- Another piece of the consistent messaging that entities find providing BH services as either losing money or maybe just able to break even--I'm guessing that includes the context where benefit costs increase but salaries may not.