The Status of Behavioral and Physical Health Integration in Alaska 2021

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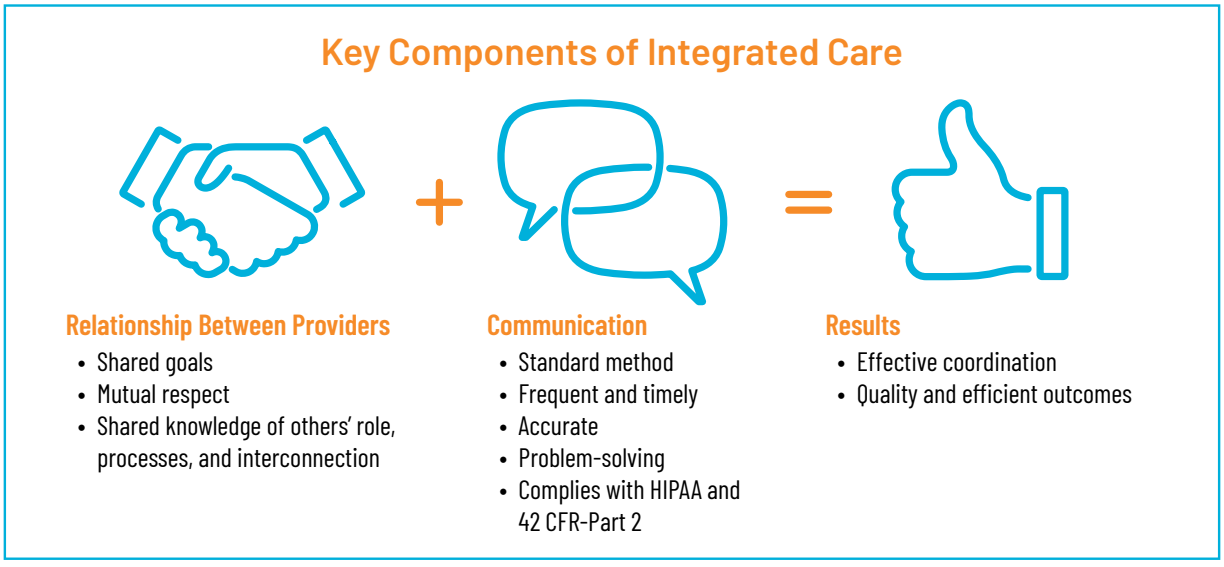
Executive Summary

Background

Integrated behavioral and physical health care can increase access to behavioral health services, especially for those individuals struggling with addiction. When someone facing a substance use disorder (SUD) is ready for treatment, it is crucial to leverage their motivation and get them into treatment immediately.

The integrated care model "widens the door" into behavioral health treatment via primary care.

When integrating behavioral health and primary care, the quality of the relationship between providers and good communication are key to producing good patient care and results. When providers understand each other's roles/processes, have shared goals and respect AND have good communication the results are more coordinated, efficient, and effective for the client/patient.



The Alaskan healthcare system is a mosaic of different approaches to healthcare delivery. One such example is the State of Alaska (SOA) Department of Health and Human Services (DHSS) Section 1115 Behavioral Health Demonstration Waiver from the Centers for Medicare & Medicaid Services (CMS). The 1115 Waiver is meant to "develop a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness (SMI), severe emotional disturbance (SED), and/or substance use disorder (SUD)." New options exist within the 1115 Waiver to bill for services to support integration of care. This project set out to better understand where Alaskan behavioral health and primary care providers are in terms of communicating and collaborating with one another, as well as to gauge the level of awareness providers have in utilizing this funding source to support integration of care for those they serve.

Methods

From June through September 2021, a survey went out to Alaskan behavioral health providers (BHPs) and primary care providers (PCPs) via a snowball sampling technique and through contact information obtained from the Professional License Database maintained by the SOA. These sampling techniques yielded a sample of 170 complete surveys.

The final sample consisted of 56% of Behavioral Health Providers (BHPs) and 44% of Primary Care Providers (PCPs). The following are characteristics of the sample:

- Place of work: urban/suburban (65%), rural on road system (31%), rural hub community (19%), remote (11%)
- Work setting: private practice (31%), Tribal organization (23%), non-profit organization (18%), Federally Qualified Health Center/Community Mental Health Center (13%), hospital or major health system (7%), other setting (8%)
- Age groups served: child/youth (60%), adults (67%), all ages (52%) [1]

The Relationship between Providers

While providers expressed mutual respect, the survey revealed significant room for improvement to increase shared goals and level of satisfaction on working together. Fifty percent of BHPs and 30% of PCPs had a dissatisfied or neutral level of satisfaction with their relationship with the other type of provider.

Communication and Making Referrals

Both types of providers rated the importance of communicating with the other type as "somewhat" or "very important." However, both groups were also "dissatisfied" or "neutral" about the quality of communication with the other type of provider. Both groups of providers listed the following top challenges:

BHPs and PCPs both said:	BHPs said:	PCPs said:
It is too hard to get a hold of providers	BHPs and PCPs do not speak the same language	I do not know how to contact BHPs
There is not enough time to reach out	PCPs do not have the same views on mental health as BHPS	It is hard to get a patient an appointment with a BHP
I don't know if the patient received services	HIPAA is sometimes used as a reason PCPs do not reach out	

Both types of providers want to talk to each other about: medication management; interaction of mental/physical health issues; services/illness/diagnoses in the other providers field; when treatment is not working.

There is no standard procedure for making referrals between PCPs and BHPs. When asked about making referrals:

- All providers rated their satisfaction level with the referral system as neutral or dissatisfied.
- 53% of PCPs and 44% of BHPs said that they "never" or "rarely" heard back from the other type of provider.
- Co-located providers reported a higher level of satisfaction with communication and referral procedures.

[1] The answers for the questions on service area and age of patients/clients served were not mutually exclusive; therefore, the total of the percentages may exceed one hundred.

Providers and Medicaid

Among the providers surveyed, PCPs were more likely to bill Medicaid for physical healthcare and BHPs to bill Medicaid for behavioral healthcare. BHPs were more likely to use the 1115 Waiver for billing Medicaid as compared to PCPs. There was a large percentage of PCPs who had never heard of the waiver (59%).

How to Improve Communication/Collaboration

Providers suggested:

- Regularly scheduled check-in meetings to discuss shared patients
- Funded care coordination and communication
- A financial incentive for integrated care in primary care clinics
- Co-locate providers and use a shared medical record

Comments by providers to improve communication included:

- Have frequent communication
- Have an on-call provider available when admitting a youth to inpatient care
- Have integrated Release-of-Information processes (ROI)
- Promote mutual understanding/respect among BHPs and PCPs
- PCPs need to value and understand BH more
- BHPs need to reach out to PCPs to tell them about available services

Suggested methods of communication:

- Face-to-face communication
- Phone, secure messaging, and email
- Shared Electronic Health Record use
- Send notes from visits

Next Steps

The current situation presents a promising opportunity for promoting integrated care in Alaska because there is a high level of mutual respect and a shared urgency among both types of providers for integration. A program that strives to increase integrated care should have the following components:

1. Training for PCPs on trauma-informed care and key behavioral health concepts
2. Training programs and webinars for BHPs and PCPs on:
    a. How to manage HIPAA and 42CFR-Part 2 requirements while providing integrated care
    b. Scope and practices of each field
    c. How collaboration, co-location, and communication can be funded, including training on the use of the 1115 Medicaid Waiver
3. Work with professional associations and groups on creating standard procedures and expectations for making referrals and standardized content for ROI forms
4. Continued efforts to increase the behavioral health workforce
5. Review the findings of this report to leverage clinical application and further integrated care in Alaska