The Status of Behavioral and Physical Health Integration in Alaska

2021 Conducted by Actionable Data Consulting
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RECOVER
ALASKA

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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.

Key Components of Integrated Care

Relationship Between Providers

- Shared goals
- Mutual respect
- Shared knowledge of others' role, processes, and interconnection

Communication

- Standard method
- Frequent and timely
- Accurate
- Problem-solving
- Complies with HIPAA and 42 CFR-Part 2

Results

- Effective coordination
- Quality and efficient outcomes

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.

A shared understanding of roles/processes/goals, combined with mutual respect and good communication results in better care and outcomes.

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

ABBREVIATIONS

The acronyms used in this report are defined below.

42 CFR-Part 2	Confidentiality of Substance Use Disorder Patient Records
AA	Alcoholics Anonymous
ACA	Affordable Care Act
BH	Behavioral Health
BHP	Behavioral Health Provider
CMS	Centers for Medicare & Medicaid Services
CMHC	Community Mental Health Center
DHSS	Department of Health and Social Services
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical Services
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act of 1996
MAT	Medication-Assisted Treatment
NA	Narcotics Anonymous
PCP	Primary Care Provider
ROI	Release-of-Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SOA	State of Alaska
SUD	Substance Use Disorder

Background

Communication between healthcare providers who share patients is considered vital and facilitates improved patient outcomes. The negative consequences of lack of communication include treatment delays, medication and diagnostic errors, patient injury and death, and increased health care costs. Between-provider collaboration and communication improve patient outcomes and satisfaction and decrease costs (Matthews, 2021). Integration of care can also serve to increase access to behavioral health services, especially for those individuals struggling with addiction. When someone facing 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 serves to "widen the door" into treatment for these individuals via primary care and behavioral health providers.

There are several names for primary care and behavioral health providers working together to provide collaborative care to a patient: behavioral health integration, integrated care, or collaborative care. The coordination of behavioral health and primary care allows providers to treat persons experiencing conditions that affect both their physical and mental health. Integration of care can also increase access to behavioral health services (Matthews, 2021). The models of integrated care range from minimal integration, with providers located in separate facilities and rare communication, to full integration with a single-system, coordinated multidisciplinary team, and frequent communication.

The Substance Abuse and Mental Health Services Administration proposed a framework with six levels of collaboration integration:

1. *Level 1 – Minimal Collaboration:* The providers have separate facilities with separate systems, rarely communicate about cases, communication is driven by provider need, there are separate treatment plans, and the providers have a limited understanding of each other's role.
2. *Level 2 – Basic Collaboration at a Distance:* The providers are in separate facilities with separate systems, they communicate periodically, patient issues drive the communication, they appreciate each other's roles, they may meet as part of a larger system, and they may share their separate treatment plans.
3. *Level 3 – Basic Collaboration On-site:* The providers work in the same facility but in separate systems. They communicate regularly about shared patients, and communication is driven by the need for each other's services. They occasionally meet to discuss cases and feel part of an informal team. They agree on specific screening and referral protocols and have separate service plans with some shared information.
4. *Level 4 – Close Collaboration On-site with Some System Integration:* The providers are in the same facility in the same space and may share some of the same systems. They communicate in person as needed and have coordinated plans for patients with high needs. They may interact together face-to-face with some patients. They understand each other's roles and culture and agree on specific screenings. There is collaborative treatment planning for specific patients.
5. *Level 5 – Close Collaboration Approaching an Integrated Practice:* The providers are in the same space within the same facility. They work to have synergistic systems and frequently communicate in person. There is a desire to work as a team together, collaboratively, and they have regular interactions together with patients. They understand each other's roles, agree on types of screenings, and do collaborative treatment planning for some patients.
6. *Level 6 – Full Collaboration in Transformed/Merged Integrated Practice:* The providers work in the same space within the same facility sharing all practice space and the same systems. They communicate consistently, both individually and as a team, through formal and informal meetings. Their roles and cultures fit together well. They use population-based medical and behavioral screening, and there is one treatment plan for all patients (National Council for Community Behavioral Healthcare/SAMHSA, 2013).

Collaboration and communication are consistently identified as crucial elements of an integrated care model. Barriers to effective communication between providers include a lack of a standard structure for communication; lack of shared goals; knowledge; and

mutual respect; differing communication style; limits on the sharing of sensitive information; and time and economic restraints. Dr. Jody Hoffer Gittell theorized that high-quality relationships and communication mutually reinforce each other, leading to the effective coordination of tasks and results in both quality and efficient outcomes. This theory proposes that shared goals, shared knowledge, and mutual respect are essential to successful professional relationships and that communication between providers should be frequent, timely, accurate, and problem-solving (Matthews, 2021).

Over the last forty years, changes in mental health treatments and federal policy and funding have shaped the service delivery model for mental health delivery and spurred an interest in integrated care. In the 1980s, selective serotonin reuptake inhibitor antidepressants brought the treatment for depression and anxiety within the sphere of primary care providers. Additionally, federal funding promoted mental health treatment in federally qualified health centers (FQHC). There have been several pieces of legislation such as the 1996 Mental Health Parity Act and the 2008 Mental Health Parity and Addiction Equity Act that have improved access to health insurance for individuals with mental illness and substance use disorders (SUDs) through the requirement of similar coverage limits for mental and physical health. Improved health care coverage for mental health conditions also created an environment for integration to grow. The Affordable Care Act (ACA) furthered integration with funding for health homes with comprehensive care coordination and improved integration at community mental health centers. The ACA also promoted the development of creative organizational and payment strategies for integrated care models.

The Alaskan healthcare system is a mosaic of different approaches to healthcare delivery. A statewide Tribal health system serves Alaska Native/American Indian peoples. Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) provide care throughout the state. The FQHCs and the CMHCs are sometimes intertwined within the Tribal System. Private clinics, large hospital systems with roots in the lower 48, non-profits, and individual providers are also part of the Alaskan healthcare mosaic. Unlike the lower 48 states, fee-for-service care is still firmly entrenched in Alaska. These healthcare settings have developed in response to federal and state policy and funding. Additionally, the State of Alaska (SOA) Department of Health and Human Services (DHSS) has been granted a 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 disorders (SUD). The demonstration project also seeks to increase services for at-risk families to support the development of children and adults through increased outreach, prevention, and early intervention supports" (Alaska, 2017).

Purpose

This research project aims to explore the attitudes, perceptions, behaviors, and recommendations of Alaskan behavioral health and primary care providers regarding the integration of care. Specifically, the survey examined the relationships and communication between these two groups of professionals. This data should be viewed as "baseline" data that can be used as a jumping-off point for efforts to improve the integration of care and access to behavioral health care.

Methods: Who Are the Providers Heard from in this Report?

Recover Alaska commissioned Actionable Data Consulting (ADC) to survey primary care and behavioral health providers, focusing on the integration of care, including understanding the level of knowledge among providers on how the 1115 Behavioral Health Waiver can improve collaboration.

The survey was launched in mid-June 2021 and continued through October 2021. It was distributed via a URL link using a snowball sampling method through staff at Alaskan healthcare organizations, including:

- The Alaska Primary Care Association
- The Alaska Behavioral Health Association
- Southcentral Foundation
- Mat-Su Health Services
- Recover Alaska
- All Alaska Pediatric Partnership
- Alaska Nurse Practitioner Association
- Alaska Academy of Physician Assistants
- Providence Behavioral Health
- Seasons of Life Counseling
- Beacon Occupational Health and Safety Services
- Sunshine Community Health Center

Additionally, the SOA Professional Licensing database was used to secure the names and addresses of Alaska residents with full professional status in the primary care and behavioral health fields. Providers in all areas of the state and in both the Tribal and non-Tribal systems were included. One thousand surveys with stamped ADC self-addressed envelopes were mailed out to these providers. These sampling techniques yielded a sample of 170 completed surveys. Nineteen surveys that were partially filled out were not included in the analysis.

The final sample had the following breakdown of primary care and behavioral health providers (Table 1). The sample was composed of 56% behavioral health providers (BHPs) and 44% primary care providers (PCPs). Most surveyed providers worked in an urban/suburban area (65%) or a rural area on the road system (31%). Nineteen percent of the providers worked in a rural hub community, and 11% provided services in a remote area. The most common type of organization for providers was a private practice (31%) following by a Tribal organization (23%). The other providers worked in non-profits (18%), FQHCs or CMHCs (13%), hospitals or major health systems (7%), or another setting (8%). The providers reported they served the following age groups: child/youth (60%), adults (67%), all ages (52%).[2]

The providers who filled out the survey reported having many years of experience. Thirty-one percent had worked in their field for longer than twenty years, 29% had worked between eleven and twenty years, 22% - six to ten years, 16% for one to five years, and 3% for less than one year.

The major limitation of this research is that the survey sample was not randomly selected and, thus, generalization cannot be made with the entire population of primary care and behavioral health providers in Alaska. The results should be interpreted as the range of perceptions, behaviors, and beliefs of these providers regarding integrated care.

[2] 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 100.

TABLE 1 - **NUMBER OF PROVIDERS SURVEYED**	
Primary Care Providers (n=75)	
Primary Care Physician	32
Pediatrician	14
Nurse Practitioner – Physical Health	14
Physician Assistant – Physical Health	12
Other Primary Care Provider	3
Behavioral Health Providers (n=95)	
Psychologist	11
Psychiatric Nurse Practitioner	3
Licensed Clinical Social Worker	21
Licensed Professional Counselor	29
Licensed Marriage and Family Counselor	1
Peer Support Worker	9
Behavioral Health Aide	4
Other Behavioral Health Provider	17

TABLE 2 - **CHARACTERISTICS OF THE PROVIDERS SURVEYED**		
	Behavioral Health Providers	**Primary Care Providers**
Years In Their Profession		
< a year	4%	1%
1-5 years	18%	13%
6-10 years	27%	16%
11-20 years	30%	27%
>20 years	20%	44%
Type of Organization		
Tribal Health System	22%	23%
Federally Qualified Health Center	23%	9%
Community Mental Health Center	11%	0%
Hospital/Major Health System	5%	8%
Private Practice	22%	43%
Non-profit Organization	29%	22%
Service Area		
Remote	14%	8%
Rural (Hub Community)	22%	15%
Rural (On Road System)	25%	25%
Urban/Suburban	32%	32%
Age Group of Patients Served		
Child/Youth	39%	87%
Adult	64%	71%
Geriatric	26%	61%
All age groups	43%	63%

Survey Data Findings

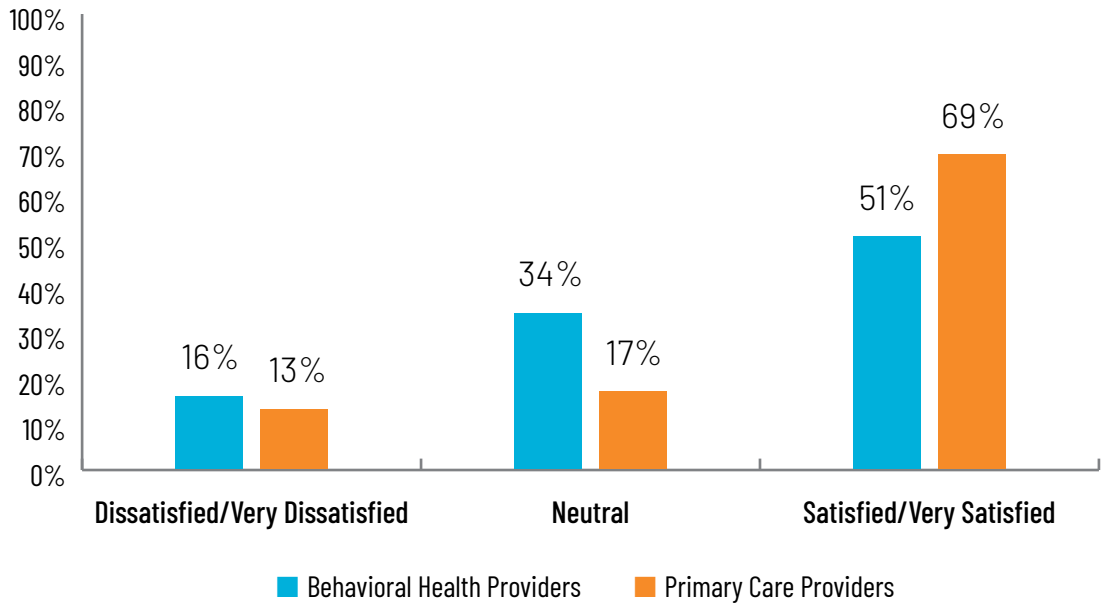
Provider Relationships

Effective and satisfying professional relationships are built upon shared mutual respect, knowledge, and goals. Each type of provider was asked to rate their level of respect for the other type of provider on a scale of one to ten, with one being a low level of respect and ten being a high level of respect.

- The average level of respect that PCPs had for BHPs was 9.30.
- The average level of respect that BHPs had for PCPs was 8.51.

Each type of provider was asked to rate their satisfaction level with the quality (mutual respect/ shared goals) of their relationship with the other provider. Sixty-nine percent of the PCPs were "satisfied" or "very satisfied" with their relationships with behavioral health providers. Fifty-one percent of behavioral health providers were "satisfied" or "very satisfied" with the relationship with PCPs (Figure 1).

FIGURE 1
LEVEL OF SATISFACTION WITH RELATIONSHIP WITH OTHER PROVIDER TYPE



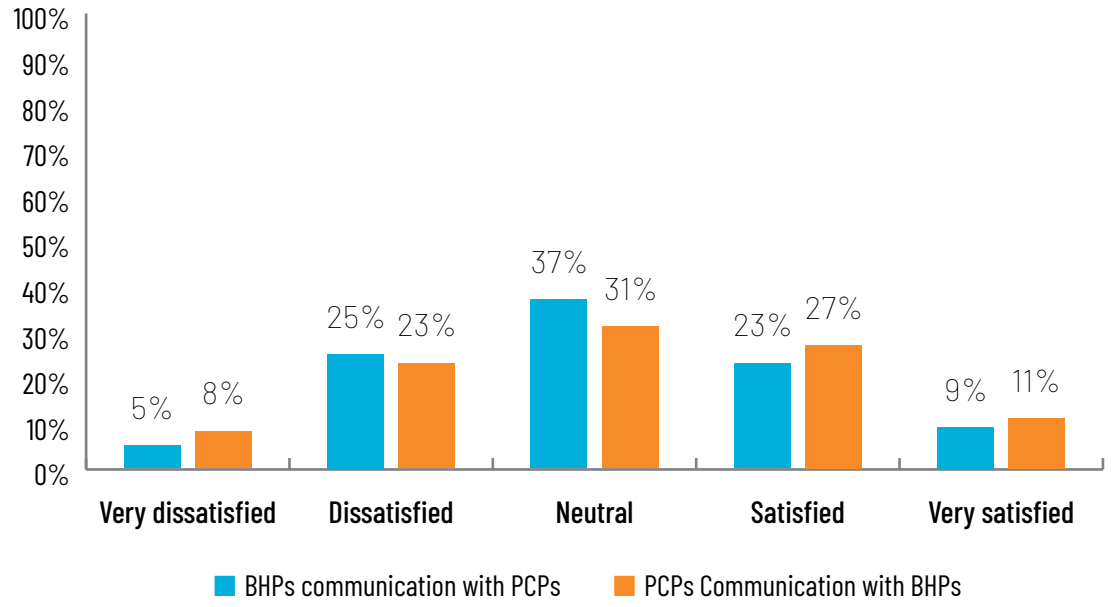
Provider Communication

Communication between healthcare professionals is best when it is frequent, timely, accurate, and contributes to problem-solving. The providers were asked to rate how important it was for them to communicate with the other type of provider if their client needed their services.

- PCPs rated the importance of communicating with BHPs about a patient in need of their service 4.38, with the score of five being very important.
- Behavioral health providers rated the importance of communicating with PCPs about a patient at 4.34.

When providers were asked to rate the quality (frequency, timeliness, and problem-solving) of communication about shared patients with the other type of provider, the same pattern was seen in the responses of both types of providers, with the majority rating the quality as neutral. Overall, PCPs appeared slightly more satisfied with their communication with BHPs than vice versa. Most of both providers reported that their satisfaction level was either dissatisfied or neutral.

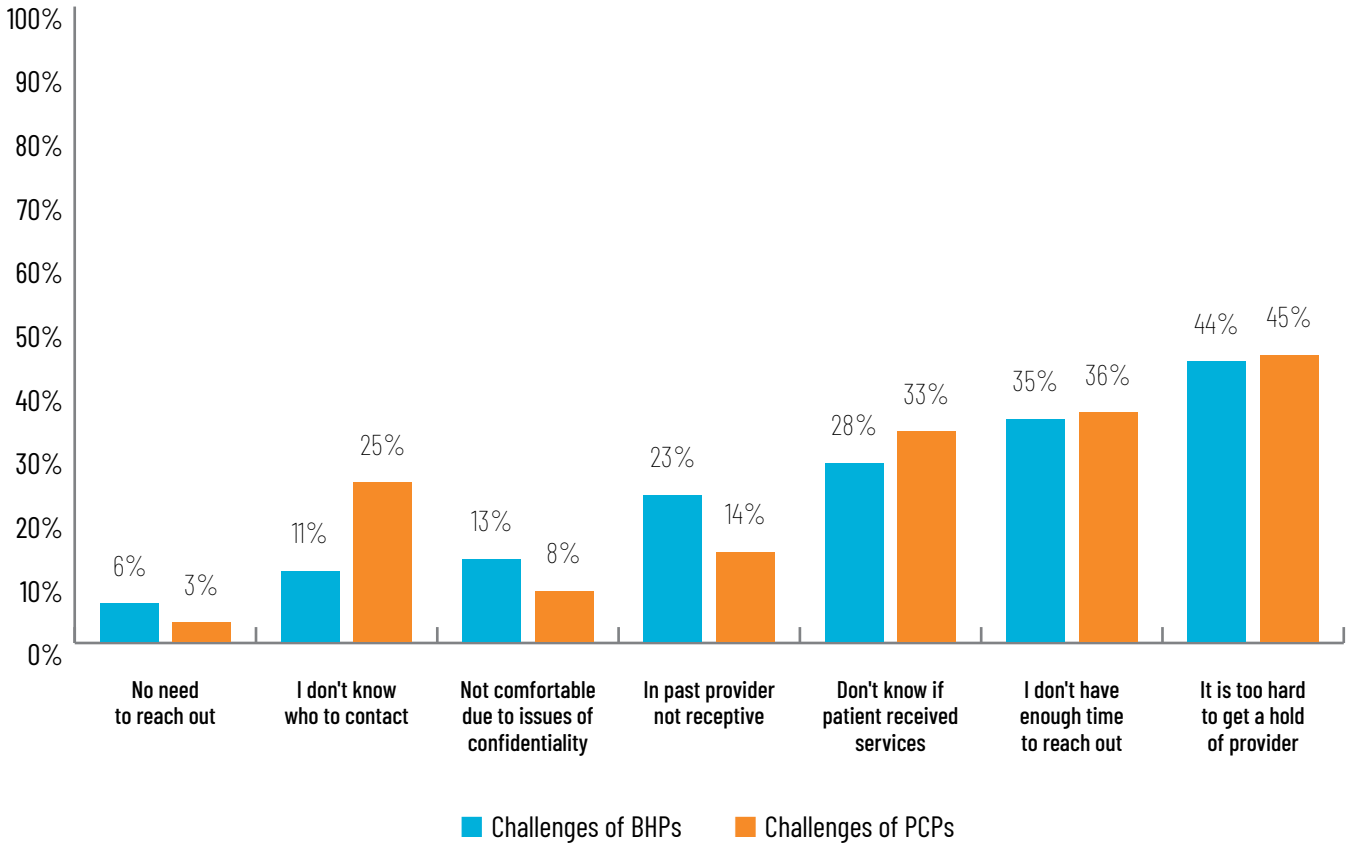
FIGURE 2
RATING OF SATISFACTION WITH THE QUALITY OF COMMUNICATION WITH OTHER PROVIDER TYPE



Each type of provider was provided with a list of challenges that they might face when trying to communicate with the other type of provider. Figure 3 shows the percent of providers who identified with particular challenges. The most common challenge cited was difficulty in reaching the other type of provider.

Other common challenges were not having enough time to reach out and not knowing if the patient/client received services from the other provider. A major difference between the two provider types was that, compared to BHPs, a higher percent of PCPs did not know who to contact to make a referral.

FIGURE 3
CHALLENGES FACED WHEN TRYING TO COMMUNICATE WITH OTHER PROVIDER TYPE



An open-ended question asked providers for specific challenges in communicating with the other type of provider about a client.

BHPs replied (direct quotes are in italics):

- *We don't speak the same language. Medical providers I have found do not have a very good understanding of how trauma impacts the autonomic nervous system and [they] treat symptoms and not the person.*
- *The use of HIPAA to avoid sharing information.*
- *Barriers due to confidentiality - most people don't really understand HIPAA.*
- *Our full-time employees are very receptive, it's the itinerant employees who don't understand Alaska that we have issues with. We need to educate people coming to work in Alaska rural areas as to* integration.
- *PCPs don't understand mental health.*
- *All primary care providers are obviously not created equal, but in general they are hard to engage unless you attend the appointment with your client because they are extremely pressed for time in most instances. Or they just don't understand the need/ benefit to them of coordinating care.*
- *Poor communication within clinic, PCPs have lack of 'buy in' of mental health services.*
- *I meet monthly with providers to discuss shared clients but wish it could happen more often.*
- *Physician turnover has significantly disrupted medical continuity of care.*
- *The patient would have to provide written authorization for me to communicate with the primary care provider or anybody else.*
- *The systems are dysfunctional and non-communicative.*
- *[There are] no challenges.*

PCPs replied (direct quotes are in italics):

- *Our integrated behavioral health clinicians work with me in the clinic setting. It's easy to access them and receive feedback about progress. But because of the rigidity of Medicaid and Medicare rules they are often not paid because Medicaid and Medicare want excessive, non-value-added charting and workflow to justify reimbursement.*
- *In general, there are not many communication problems, and I am immediately reached out to.*
- *They never send a chart note, when asked for the note, they decline even though I was the referring provider.*
- *[We have] collegial relationships with congenial providers.*
- *HIPAA Barriers.*
- *I often phone the provider to refer the patient to them.*
- *Behavioral health [providers] refuse to communicate about patients I refer to them.*
- *Very poor reciprocation of records and plans of care.*
- *Since I do not refer directly, I don't know who they have seen.*
- *It is difficult to find a provider to accept my patients.*
- *Reaching out for a referral doesn't mean my patient will see the person [I make the referral to.]*
- *BHP communication is less dependable - time is always an issue.*
- *Emergency care (especially psychiatric) can be very difficult to access.*
- *We meet monthly and discuss our clients.*
- *There are long waits and patients have trouble being seen in a timely manner.*
- *Usually able to connect.*

Provider Communication Topics

Providers were asked what they wanted to discuss with the other type of provider. The topics that each group suggested were very similar. Both types of providers mentioned needing to discuss medication management, the reciprocal impact of mental and physical health, the need for additional services that the other type of provider would know about, and when there is noncompliance or treatment is not working. Each type of provider also had a list of specific types of illness/diagnoses about which they wished to consult with the other provider.

TABLE 3 - **TOPICS THAT PROVIDERS WANT TO DISCUSS WITH EACH OTHER**

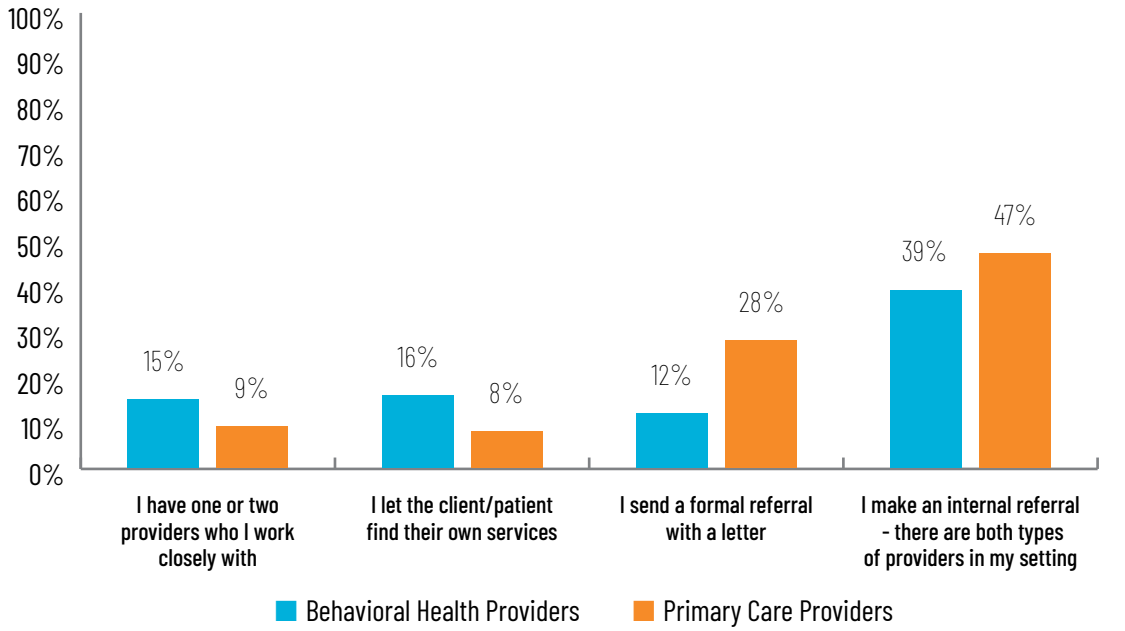
BHPs Want to Communicate with PCPs About	PCPs Want to Communicate with BHPs About
Medication management	Medication management, mental health support with Vivitrol
Physical health status	Unstable mental illness, unstable physical health
Interaction of mental and physical health	Changes to physical health due to mental health
Share assessment and treatment plan	Share notes, treatment plan, recommendations
Symptoms not improving, changing, noncompliance	Patient is lost to follow-up; seen by the Emergency Department; or had an EMS visit
When additional specialty services are needed	Connection to AA/NA/MAT, when to involve child psychiatry, when to order neuropsychological testing
When concerned or stumped about client's care	When the BH disorder is uncontrolled or trying to capitalize on new motivation to engage in treatment
Sleep concerns, headaches, stomach pain	Suicidality, family conflict, acute psychosis, unmanageable life stressors, bipolar personality disorder, sexual assault, autism, chronic health conditions, gender concerns, homicidal ideation, cutting
Information on intake/discharge from a facility	
If they referred the patient	

Making Referrals

There is no standard system for making referrals between the two provider types. Providers were asked to rate their level of satisfaction with the system they now use for making referrals to the other type of provider, and their responses were very similar. BHPs rated their satisfaction at 3.57 (Neutral), and PHPs rated their satisfaction at 3.31.

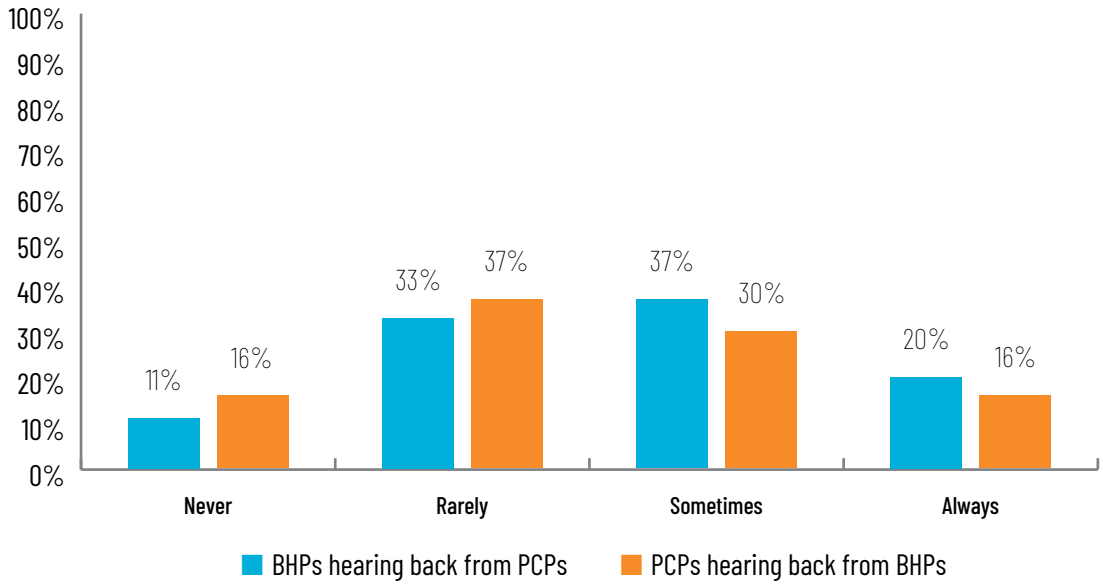
Providers were asked how they usually handle a patient referral to the other type of provider. The most common response from both types of providers was that they work in a setting with both kinds of services, and they use an internal referral system (Figure 4). The second most common method to make a referral for PCPs was sending a referral letter (28%), while the second most common practice for BHPs was to let the client/patient find services on their own. A response that was not listed for this multiple-choice question but was repeatedly supplied by respondents in the "Other specify" option was that they or another staff member provided a "warm handoff" to the other type of provider and/or helped the person find a provider.

FIGURE 4
HOW DO YOU MAKE REFERRALS?



Both types of providers were asked how often they heard back from the other type of provider after a referral. BHPs are slightly more likely to hear back from PCPs. Forty-six percent of PCPs sometimes/always heard back from BHPs compared to 57% of BHPs sometimes/always hearing back from PCPs (Figure 5).

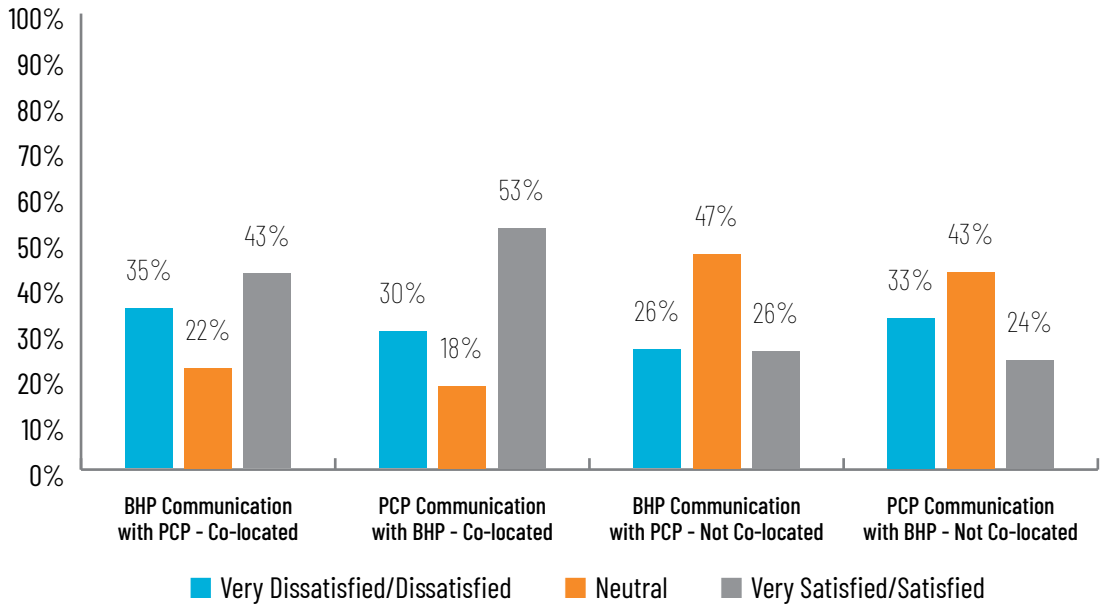
FIGURE 5
WHEN YOU MAKE A REFERRAL HOW OFTEN DO YOU HEAR BACK FROM THE OTHER PROVIDER TYPE?



Integration

Forty-seven percent of PCPs and 39% of BHPs – 72 providers in all, reported that they had both types of services in-house. Co-located providers reported higher satisfaction levels with their communication with the other type of provider (Figure 6).

FIGURE 6
CO-LOCATION – SATISFACTION LEVEL WITH QUALITY OF COMMUNICATION



When comparing the level of satisfaction (on a 5-point scale with 5 being "Very Satisfied") with the referral-making procedure between service types, the mean satisfaction level was higher for those who were co-located.

- Co-located BHPs rated their procedure for making referrals to PHPs at 4.04 compared to a 3.28 rating from providers who were not co-located.
- Co-located PHPs rated their procedure for making referrals to PHPs at 3.58 compared to a 3.03 rating from providers who were not co-located.

Co-located providers were more likely to hear back from the other type of provider. Figure 7 shows that 62% of co-located PCPs reported "always" or "often" hearing back from BHPs providers compared to only 34% of PCPs who were not co-located with BHPs. Similarly, 64% of co-located BHPs reported "always" or "often" hearing back from PCPs. This response rate dropped to 54% for BHPs who were not co-located with PCPs.

FIGURE 7
CO-LOCATION – WHEN YOU MAKE A REFERRAL HOW OFTEN DO YOU HEAR BACK FROM THE OTHER PROVIDER TYPE?

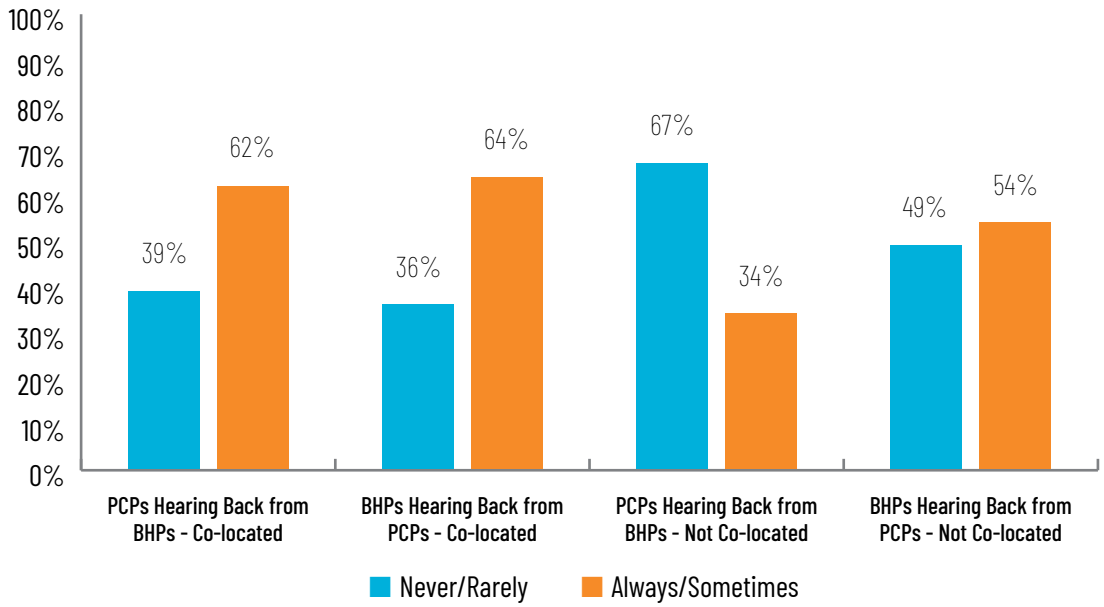
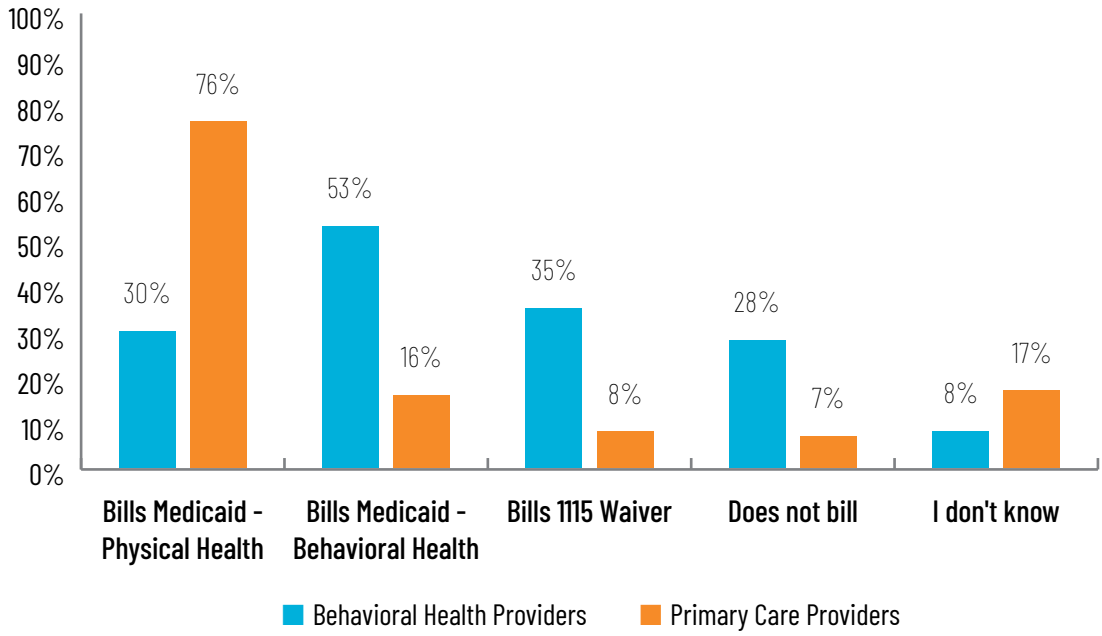


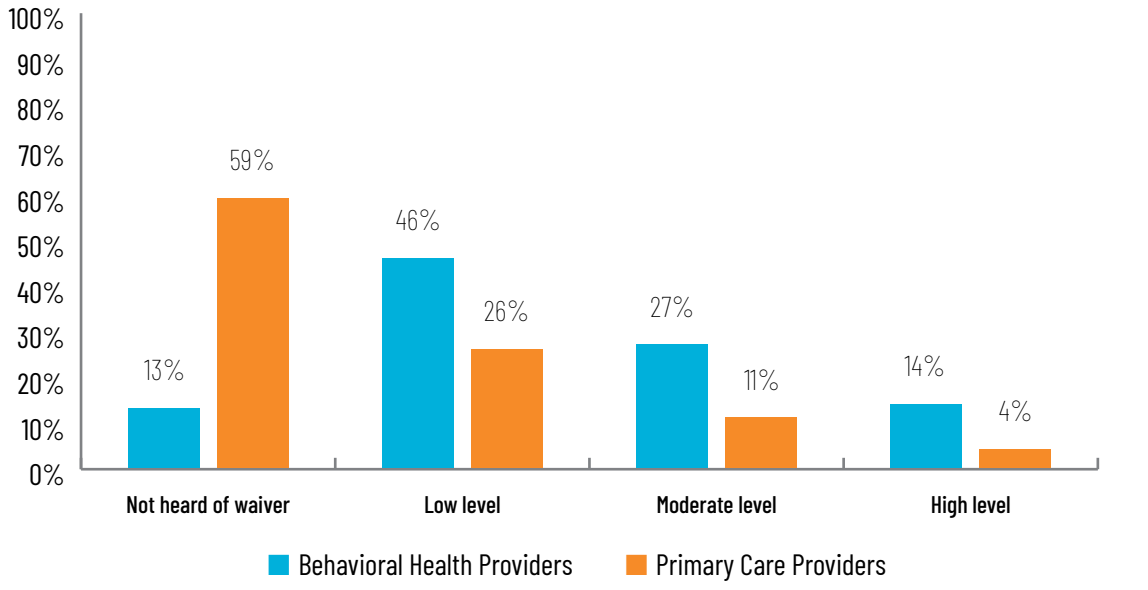
FIGURE 8
DOES YOUR PRACTICE BILL MEDICAID?



Providers and Medicaid

Of the providers surveyed, most PCPs (76%) billed Medicaid for physical healthcare, and just over half of BHPs (53%) billed for behavioral health care (Figure 8). More BHPs billed through the 1115 Waiver (35%) than PCPs (8%). More BHPs did not bill Medicaid at all (28%). It is important to remember that this survey did not use a random sample; therefore, these percentages describe the unique group of providers who filled out the survey instead of all providers in Alaska. As seen in Figure 9, of the providers surveyed, it was more common for PCPs not to have heard about the 1115 Waiver (59%) compared to BHPs (13%).

FIGURE 9
PROVIDER LEVEL OF UNDERSTANDING OF 1115 WAIVER



Provider Recommendations

When providers were asked how communication between BHPs and PCPs could be increased, their answers focused on the following themes (see all responses in Appendix B):

- Scheduling time for communication/collaboration
- Co-location and integration
- Promotion of policy and funding that supports integration
- Electronic Health Records
- Better understanding each other's scope of work and practices
- Examples of possible communication methods
- The transfer of documents
- Increasing the behavioral health workforce and the number of case managers

Providers suggested that it would be helpful to have regularly scheduled meetings or a window of time on the schedule to confer with the other type of provider. Additionally, several providers called for more team/integrated-care conferencing. These comments were tied to comments about the need for funding to cover time spent to communicate and coordinate care. Also, providers recommended that reimbursements be sufficient for the inclusion of behavioral health care in the primary care clinic. Providers recognized the usefulness of having both provider types in a single setting, and many of their recommendations focused on co-locating and sharing medical records. Several providers suggested using a shared EHR to help increase integration. One provider called for closer alignment of regulations and systems in the two fields so that it is easier for both types of providers to understand how the workflow and care are managed.

Comments by providers included that the communication should be regular, and an on-call provider should be available when a youth is admitted to inpatient care. They suggested integrating ROIs as part of the outpatient and inpatient admission process to allow free communication between provider types. The communication methods recommended included face-to-face meetings, secure messaging, phone, text, email, and Electronic Health Record use. Overwhelmingly, both groups of providers wanted to receive notes from visits with the other type of provider.

Many suggestions related to staffing. The most common requests were for more BHPs to allow more patients to receive care and allot more time for communication with PHP providers. There were a few requests for more PCPs as well. Some providers also requested more case managers to assist with communication and advocate for client needs.

Many of the recommendations centered on the need for providers to better understand and respect each other. Several BHPs noted the need for PCPs to value and understand behavioral health more. Some stated that both types of providers needed a better understanding of the other's field and rules. Comments from PCPs included the need for more outreach from BHPs in their areas so that the PCPs would know to whom to refer their patients.

Summary and Next Steps

Both types of providers respect and value the other and have a very strong desire to communicate and coordinate care for the people they serve. There are common themes in the content of the information they want from each other, and both types of providers face similar challenges in contacting each other. PCPs expressed more frustration about not having their patients seen due to insufficient numbers of BHPs, and they said that they rarely heard back from BHPs. BHPs were concerned that PCPs did not understand behavioral health issues and often used HIPAA as a reason not to reach out.

There is no standard way of making referrals between PCPs and BHPs in Alaska. This gap may contribute to low levels of satisfaction with referral practices for both types of providers. Many providers never heard back from the other provider type after making a referral. Co-located providers had less dissatisfaction with the referral system and were more likely to hear back after making a referral. There is a low level of understanding and use, especially among PCPs, about an important tool for integration, the 1115 Medicaid Waiver.

Provider recommendations for increasing integration included scheduling regular times for communication, including open windows and set team/check-in meetings; identifying standard methods of communication; training and relationship-building to increase knowledge and respect about each other's

fields. PCPs noted the need for more BHPs to see their patients. There was also a request from both types of providers for case managers to help with coordination.

The current situation presents a promising opportunity for promoting integrated care in Alaska, which will help to get people with mental health and substance use needs the care they need when they need it. There is a high level of mutual respect and a shared urgency among primary care and behavioral health providers for the need for such integration. They have specific requests for information that will improve their ability to care for patients/clients. Based on the findings from this survey, 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 on how to manage HIPAA and 42CFR-Part 2 requirements while providing integrated care.
3. Training and relationship building for PCPs and BHPs on the scope and practices of each field.
4. Work with the professional associations and groups on creating standard procedures and expectations for making referrals, standardized content for the release-of-information forms that address HIPAA and 42 CFR-Part 2, and communication between providers.
5. Education for both groups of providers on how collaboration, co-location, and communication can be funded, including training on the use of the 1115 Medicaid Waiver.
6. Continued efforts to increase the Behavioral Health workforce.
7. Review the findings of this report in a way to leverage clinical application furthering integrated care in Alaska. Develop training programs and webinars for provider education, specifically for PCPs.

Appendix A: References

Alaska, S. o. (2017, November 28). *Department of Health and Social Services Notice of Public Comment Process for Medicaid Section 1115 Behavioral Health Demonstration Waiver*. Retrieved from Online Public Notices: **https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=187926**

Goldman, B. D. (2018). Integrating Health and Mental Health Services: A Past and Future History. *The American Journal of Psychiatry*, 1199-1204.

Matthews, K. (2021). Primary Care and Behavioral Health Provider Communication Strategy for Improvement. *The Journal for Nurse Practitioners*, 865-869.

National Council for Community Behavioral Healthcare/ SAMHSA. (2013). *A Standard Framework for Levels of Integrated Healthcare*. SAMHSA-HRSA Center for Integrated Health Solutions.

Appendix B: Provider Suggestions for Improving Integration

The following are recommendations made by the survey participants. Direct quotes are in italics.

Scheduling

Regularly Schedule Check-ins or Available Times for Communication

- *Regularly scheduled meetings.*
- *PCPs need to the time and the commitment to integration. Organizations need to value and ensure that providers are given time for communication.*
- *I think that more time built into the schedule for collaboration would help in the outcomes of treatment for both. Perhaps having open office hours for collaboration with community behavior health providers. Having a real time way to share data related to patient care.*
- *Not all providers (MD or Behavioral Health) have consistent times available to connect professionally.*
- *Add more hours to the day. Lol.*
- *Dedicated time in schedule for follow up calls.*
- *Time needs to be dedicated.*
- *Tricky - time is the limiting factor. When I work a 16-hour day nonstop, there is simply no more time for me to do anything.*
- *We have both internally in our Tribal Health Organization, so this is less of a challenge for us than others. I think routine meetings between the disciplines on shared clients and shared workflows/ concerns is critical to keeping open communication and showing the value of each person on the team.*

Team Meetings

- *Monthly/quarterly team meetings.*
- *Team meetings bimonthly.*
- *By creating care teams that meet regularly.*
- *Have primary care present at case conferencing.*
- *More integrated care conferences!! This is where people network and take time out of their schedules.*

Funding

- *Adequate reimbursement of behavioral health such that it can be normally part of primary care.*
- *Allot the time and compensation for care coordination.*
- *If the idiots in charge of MC/MC made it easier to work in the same office space by rewarding practices that do so and pay those programs more favorably it could be discussions between office mates for comprehensive wrap around care. But since MC/ MC has done everything, it can create a culture of fear about information sharing and made charting the primary focus its far more expensive* and time consuming than it must be.
- *Unfortunately, one of the main ways would be to be able to bill for a team meeting between a primary care provider and then LCSW or another licensed provider.*
- *We should refer to who we respect/work with/know - but are restricted by patient's insurance.*

Co-locate/Integration

- *Behavioral health providers located within primary care offices; and assigned to the same care team.*
- *Have them integrated with our practice.*
- *Big fan of integration. Make ROIs easier to share, easy to find contact info for providing in community.*
- *More integration between the two in the same office - - better reimbursement/coverage - medical payments low; insurance deductibles/copays increasing.*
- *By having both sides in the same building.*
- *Collaboration of services.*
- *Same office would be helpful.*
- *Being integrated (sitting with primary care team) and having back-to-back appointments with both definitely helps.*
- *More integrated care conferences!! This is where people network and take time out of their schedules.*
- *We don't have a problem.*
- *Integrate behavioral health into primary care.*
- *Co-location and shared medical records.*
- *Partnering with agencies (predetermined).*
- *Integration and collaboration between the two in all practices.*
- *Better reciprocation from BH providers and coordination of care plans.*

Policy

- *The regulations and systems in the two fields need to align closer so that it is easier for both types of providers to understand how the workflow and care is managed.*

Better Understand Each Other

- *Treatment team meetings, and regularly staff meetings to build understanding and relationships*
- *Having the doctors value it enough to make time for regular meetings.*
- *Behavioral health providers may want to reach out to clinics to make them aware of their presence.*
- *Campaign to increase awareness of behavioral health services.*
- *Better communication and understanding of mental health issues.*
- *Yes, it would be good to have mutual awareness of services and needs in our community.*
- *Shared understanding of benefits of all parties in the relationships.*
- *Continuing education programs with CME and CEUs etc. Newsletter with examples (respecting patient and practitioner) confidentiality Statewide ECHOs for improved outcomes like currently offered for contact tracers, science, vaccine.*
- *Primary care providers must value BH more.*
- *A better understanding of the scope and limitations of each.*
- *I think it needs to start by bringing them together to discuss how to best utilize their interactions to best help clients.*
- *Educating itinerates about what the BHA's do.*
- *More respect and understanding for what the BH Teams do and their roles in the system.*
- *More outreach and education from DBH to primary care providers.*
- *More education on privacy laws.*
- *Learning about one another's field, we assume we know how we work with our clients but developing a sense of trust and understanding, building positive relationships and respect for one another's field will benefit our clients.*
- *Make it easy, accessible, and informational, with respect to both sides of care.*
- *Fix their interpretation of the rules.*
- *There is so much taboo about mental health that even health and mental health professionals don't communicate. Behavioral health thinks that mental health is a separate department, and nothing is discussed with the pediatrician. It is very hard to work in a divided system when the goal is to provide the best healthcare according to the WHO definition of health.*
- *Perhaps accountability.*
- *It's provider dependent, a few believe they know better than BH providers.*

Communication

How often

- *When PCP's within the organization see their patient regularly, they should consult with clinician on a regular basis (after each appt).*
- *N/A to me - I need an on-call person to speak with (when kid is admitted to hospital)!*
- *Integration, normalizing the connection between physical/mental health at intake - complete 42-CFR ROIs as part of intake process.*

Content of Communication

- *Depends on client needs. The more medical issues/ conditions (TBI, SA, Chronic pain) the more beneficial talks would be especially regarding benzodiazepine prescriptions and opiate prescriptions.*

Request of Information

- *ROIs should be mandatory.*
- *Having something in place with authorization from patient/caregiver for the exchange of information without violating HIPAA.*
- *Offering patients, a ROI when they establish their BH team may improve our ability to coordinate more than just the1st appointment with BH.*

More Response

- *Provider choice - clinic choice sadly you cannot make people call you back.*

Policy/Procedures

- *Review policy and establish procedures that promote more open communication.*
- *I'm OK with my current communication.*

Communication Methods

- *Use of EMR with protected access - i.e. break the glass type of access.*
- *Get rid of EHRs so we actually have time to practice medicine and talk to colleagues.*
- *Pretty unidirectional - they don't call me. Electronic messaging through the EMR is particularly helpful. It would be nice if there was a way the PCP could acknowledge receipt of our detailed reports - even just an electronic signature would be an improvement.*
- *I think that sharing a health record through something like health Econnect could go a long way and education about how to interact with people experiencing mental health challenges would also go a long way. Our clients need to receive medical care from their providers not just referrals to psychiatry because their behaviors are not always ideal for the typical primary care setting.*
- *Health Information Exchange*
- *Electronic Health Record*
- *Good EMR systems*
- *Face to face.*
- *Secure messaging helps along with good contact names/numbers.*
- *Pick up the phone - Tiger text.*
- *Direct lines of communication being open.*
- *Calling one another or sending an email.*
- *The system we have set up enables a lot of communication as we have integrated behavioral health consultants and co located psychiatrists.*
- *Communication via electronic medical record. Easier access to chatting on the phone.*
- *Email contact or releasing records.*
- *Identify existing communications structures already in place between PC/BH. Create champions for this work.*
- *Better record keeping and communication systems*
- *There needs to be some way to communicate that is more immediate and effective. The phone isn't a good way to catch people, email seems better however it's hard as well as you can't identify who you are talking about.*
- *It would be great to have HIPAA-compliant software to message the physician. It is also helpful to schedule these types of calls. It would also be most helpful if the physician would talk directly to BH providers and not have their RN do it on their behalf.*
- *With secure communication signals and clear delineation of on call behavioral health personnel.*
- *Freedom to share information; Database of providers and services provided.*
- *I could give my contact information and introduction sheet with counseling option/contact list but would require patient to pass this along or could reach out to each behavioral health office and let them know I am interested in communication. A few times the counselors have reached out to me and we have had helpful phone conversations.*

Sending Information

- *Just receiving basic chart notes would be nice.*
- *More thorough referrals, sending records, letting providers know if a client has been seen*
- *by talking to one another and not waiting two weeks for a response.*
- *Send PCP a note after first visit and then maybe monthly.*
- *Send me notes, call my cell phone if needed.*
- *Written summary of care.*
- *It is at zero now, so even rudimentary updates (e.g. the patient was seen for an appt. would be a huge improvement).*
- *Forward copy of notes for care coordination purposes.*
- *Follow up - send notes to referring clinician just like any other specialist referrals.*
- *I have had some send me reports after getting the patient's approval.*
- *Monthly summary from behavioral health to me: # visits, issues addressed, any medical concerns, any medication recommended or being taken.*
- *If we started copying each other on notes. If BH providers, esp. Med Psych - could be available*

for provider-to-provider phone consults or med management. That would be so helpful.

- *Follow up note both ways are helpful.*
- *Primary MD should secure receive a consult note with diagnosis and treatment goals periodically, just like another specialist send.*
- *Faxing chart notes.*
- *Because of close links between physical health and mental health, sharing BOTH ways between primary care and mental health providers for changes, assessments, updates to health profile, etc. Primary care providers are often just receivers of information and don't necessarily send out information to other providers.*
- *Utilizing the systems in place within most EMR systems especially when they are protected.*

Staffing

- *Have in house behavioral health specialist.*
- *Zoom meetings of providers and multi-provider case managers with networking line, with emails, reporting client progress, funding more case manager positions, with BH training to support inter-agency communication. Perhaps licensing or certification process for funding the positions for case managers whose education/training would emphasize this communication.*
- *Lack of staff, frequent change of staff equals communication decreased.*
- *More behavioral health providers which would increase their time and ability to communicate.*
- *Difficult without more BH sources around. Lots of client needs. Long wait list to get the best help.*
- *Communicating with BH providers would be great, but it'd be better to have providers to refer to - unable to find enough resources.*
- *There is need to have better and available various internet services. Most of the services are provided through telehealth.*
- *More providers*
- *Having enough providers of both types and having enough time to do warm hand-offs all the time.*
- *Better staffing in BH with incentives to stay (live and work in our community) for >2 years.*
- *Main contact person at each health center in rural areas; couple of main contacts at larger primary care facilities.*
- *We need more behavioral health agencies in Fairbanks. One is NOT enough for the population in need.*
- *We need more of both so until we get more of them it's going to be hard to do so*
- *Easier access to these resources.*
- *Direct referrals with appointments within one week.*
- *Primary care offices having a case manager, or someone who has dedicated time for communicating with other agencies could surely help.*
- *Creating 'pods' of BH providers and medical providers means one collaborative relationship can cover many patients. Working in the same area also allows for informal conversation much more easily.* Formal meetings tend to miss the benefits of ongoing and *daily opportunities to collaborate.*
- *By having good case managers who advocate for the client's care/needs.*

Appendix C: Survey Instrument

Behavioral Health and Primary Care Integration Survey

1. Please check your provider type. If you consider yourself more than one type of provider, please select the one that represents the majority of work that you perform.
    - Pediatrician
    - Primary Care Physician
    - Nurse Practitioner - Physical Health
    - Physician Assistant - Physical Health
    - Other primary care provider
    - Licensed Clinical Social Worker
    - Licensed Professional Counselor
    - Licensed Family and Marriage Counselor
    - Psychologist
    - Psychiatrist
    - Psychiatric Nurse Practitioner
    - Physician Assistant - Behavioral Health
    - Peer Support Worker
    - Behavioral Health Aide
    - Other behavioral health provider

2. How do you currently handle coordinating primary care and behavioralhealth for your clients/patients who need both types of care?
    - I give my client/patient a list of names and numbers of providers they cancall
    - I have both services in my organization and I make an internal referral
    - I make a formal referral with a letter to the provider I am referring tointroducing the patient/client
    - I let the client/patient find their own services
    - I have one or two providers who I work closely with to whom I refer theclient/patient.
    - Other - Write In (Required)

3. Please identify your level of understanding of how the State of Alaska 1115 Medicaid Waiver can help primary care/behavioral health providersprovide coordinated behavioral health and primary care
    - I have a high level of understanding
    - I have a moderate level of understanding
    - I have a low level of understanding
    - I have not heard of the 1115 Medicaid Waiver

4. Please check all that apply about your practice/organization as it relates to Medicaid billing.

    - My organization/practice bills Medicaid for physical health services
    - My organization/practice bills Medicaid for behavioral health services (Optum)
    - My organization bills Medicaid under the 1115 Medicaid Waiver (Optum)
    - My practice does not bill Medicaid
    - Other - Write In (Required)
    - I don't know

5. In terms of behavioral health and primary care, what would you like to learn about coordinating care for your clients/patients?

6. To which population do you provide services?
    - Child/Adolescent
    - Adult
    - Geriatric
    - All of the above
    - Not applicable

7. How long have you worked in your current discipline?
    - Less than a year
    - 1-5 years
    - 6-10 years
    - 11-20 years
    - More than 20 years

8. What type of area do you serve?
    - Urban/Suburban (i.e. Anchorage, Fairbanks, Juneau, Palmer/Wasilla core area)
    - Rural (on road system)
    - Rural (Hub communities- i.e. Bethel, Dillingham, Nome)
    - Remote

9. Please categorize where you work:
    - Tribal health system
    - Federally Qualified Health Clinic/Community Mental Health Center
    - Major health system (i.e. Providence, Alaska Regional; Mat-Su Regional)
    - Private practice
    - Non-profit organization
    - Other - Write In

Behavioral Health Provider Page

Page entry logic:
This page will show when: #1 Question "Please check your provider type. If you consider yourself more than one type of provider, please select the one that represents the majority of work that you perform." is one of the following answers ("Licensed Clinical Social Worker","Licensed Professional Counselor","Licensed Family and Marriage Counselor","Psychologist","Psychiatrist","Psychiatric Nurse Practitioner","Physician Assistant - Behavioral Health","Peer Support Worker","Behavioral Health Aide","Other behavioral health provider")

10. Please rate your level of satisfaction with the system you have for referring clients to a primary care provider.

    Answer scale: 5 points from Dissatisfied to Satisfied

11. When you make a referral, how often do you hear back from the primary care provider on the assessment or care they are providing to your client?
    - Always
    - Sometimes
    - Rarely
    - Never

12. What challenges do you face when you try to communicate with a primary care provider about your client? (Please check all that apply)
    - I don't have enough time to reach out
    - I don't feel comfortable reaching out due to issues of confidentiality
    - I don't know if the patient/client actually received services
    - I don't think there is a need to reach out
    - When I have reached out in the past the other provider was not receptive
    - I don't know who to contact
    - It has been too hard to get a hold of the other provider
    - Other - Write In (Required)

13. Please rate how important to you to communicate with a primary care provider if your client needs their services?

Answer: 5 point scale from Very Important to Not Very Important

14. Please list examples of when you would want to communicate with a primary care provider about your client.

15. Please rate the level of respect you have for primary care providers, in general.

Answer: 5 point scale from A Low Level of Respect to A High Level of Respect

16. Please rate the level of understanding you have regarding your ability to share health information with a primary care provider while being within compliance with the HIPPA/42 C.F.R Part 2 regulations.

Answer: 5 point scale from I Fully Understand the Regulation to I Don’t Understand the Regulations

17. How do you rate your satisfaction with the quality of the relationships (mutual respect and shared goals) you have with primary care providers?

- Very Dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very Satisfied

18. How do you rate the quality of communication (frequent, timely, focused on problem solving) you have with primary care providers over shared patients?

- Very Dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very Satisfied

19. Please share any comments that you have regarding the questions on this page.

Primary Care Provider Page

Page entry logic:
This page will show when: #1 Question "Please check your provider type. If you consider yourself more than one type of provider, please select the one that represents the majority of work that you perform." is one of the following answers ("Pediatrician","Primary Care Physician","Nurse Practitioner - Physical Health","Physician Assistant - Physical Health","Other primary care provider")

20. Please rate your level of satisfaction with the system you have for referring patients to a behavioral health provider.

Answer: 5 point scale from Dissatisfied to Satisfied

21. When you make a referral, how often do you hear back from the behavioral health provider on the assessment or care they are providing to your patient?

- Always
- Sometimes
- Rarely
- Never

22. What challenges do you face when you try to communicate with a behavioral health provider about your patient? (Please check all that apply)

- I don't have enough time to reach out
- I don't feel comfortable reaching out due to issues of confidentiality
- I don't know if the patient/client actually received services
- I don't think there is a need to reach out
- When I have reached out in the past the other provider was not receptive
- I don't know who to contact
- It has been too hard to get a hold of the other provider
- Other - Write In (Required)

23. Please rate how important it is to communicate with a behavioral health provider if your patient needs their services?

Answer: 5 point scale from Very Important to Not Very Important

24. Please give examples of when you would want to communicate with a behavioral health provider about a patient.

25. Please rate the level of respect you have for behavioral health providers, in general.

Answer: 5 point scale from A Low Level of Respect to A High Level of Respect

26. Please rate the level of understanding you have regarding your ability to
share health information with a behavioral health provider while being within compliance with the HIPPA regulations.

Answer: 5 point scale from I Fully Understand the Regulation to I Don't Understand the Regulations

27. How do you rate your satisfaction with the quality of the relationships (mutual respect and shared goals) you have with behavioral health providers?

- Very Dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very Satisfied

- 28. How do you rate the quality of communication (frequent, timely, focused on problem solving) you have with behavioral health providers over shared patients?
- Very Dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very Satisfied

29. Please share any comments that you have regarding the questions on this page.

30. What are your thoughts or questions about the integration of primary care and behavioral health for patients/clients?

31. How do you think communication between primary care and behavioral health providers can be increased?

32. Please add any other comments you would like to share.

33. Please give us your name and email address if you would like a copy of the results of this survey and/or to be considered for the $100 gift card we will award to a respondent

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