INCREMENTAL STEPS IN A CHALLENGING FISCAL ENVIRONMENT

In the current fiscal environment, local and state governments are facing unprecedented budgetary pressures and fiscal constraints. It is more likely that jurisdictions may stage their pathway toward a close and fully integrated system. A tiered approach, albeit longer, may provide policymakers and other planners with an opportunity to obtain (and ensure) forward momentum. Table 13 provides an outline as to how a jurisdiction may take incremental steps in a challenging fiscal environment. Understandably, it would be beneficial to consider addressing the first tier before moving forward as these activities seek to reveal and maximize existing resources.

TABLE 13: INCREMENTAL STEPS FOR INTEGRATING CARE

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
Maximizing Existing Resources	Identify and empower a senior-level health leader with authority and accountability for developing a strategic integration plan.	Implementation of a shared strategic plan within state departments of health and human services, or the equivalent.
	Perform a comprehensive statewide environmental assessment that goes beyond departments. Include many perspectives such as provider and payer types.	The Federal Partners Primary Care/ Mental Health Integration Workgroup undertook a comprehensive review of federal agencies that included cataloging funding initiatives (Weaver 2008). An example: Medicaid EPSDT requirements (Title XIX) mandate comprehensive and preventive child health programs for individuals under the age of twenty-one. Preventive care services to identify physical and mental conditions must be provided during the beneficiaries' well-child visits. States also must provide other necessary health care, diagnoses services, treatment, and other

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
		measures to correct or ameliorate defects as well as treat physical and mental illnesses and conditions discovered by the screening services (U.S. Department of Health and Human Services 2008).
	Integrate financial data for the purpose of analysis. Payment for services is often siloed within different systems, making total costs elusive. One example is when behavioral health is carved out.	Understanding of the total cost of care for an individual. Knowing the clinical profile of the highest-cost patients.
	Conduct a comprehensive review of laws that prevent communication and exchange of pertinent health information and seek to remove those barriers.	An example: the State of Wisconsin Act 108 removed state-imposed barriers to the exchange of information (State of Wisconsin Department of Health and Family Services 2007).
	Create standard protocols for laws outside of jurisdiction that support and promote the exchange of information between service providers. The protocols should clarify confidentiality provisions of HIPAA, state, and federal laws as they impact the exchange of information. Ensure that integrated care is part of the discussion regarding new HIT standards and meaningful use definitions.	A standard consent form that is state endorsed and can be used across the continuum of care.

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
	Realign current workforce infrastructure to support evidence-based integrated care. Existing resources can be leveraged across systems.	Expansion of mental health case managers' roles to improve patient access to preventive primary care services. Expansion of disease management programs to incorporate behavioral health screenings and clinical pathways.
	Identify what information derived from administrative claims data is meaningful to providers and care managers caring for patients with behavioral and/or chronic conditions.	Reports of adverse events, medication compliance, or the absence of appropriate follow-up to identify gaps in care. If developed around the patients' needs versus the specific discipline of the provider, more collaborative and integrated processes will be encouraged.
Initial Investment of Resources	Develop medical home initiatives. Increasing health care reform discussions appear to support a medical home or primary care case management (PCCM) model. Generally, these models must demonstrate budget neutrality. For example, in the Community Care of North Carolina program, hundreds of millions of dollars have been saved by managing the highest-cost and highest-risk recipients through a population management strategy (North Carolina Foundation for Advanced Health Programs 2008).	Primary care provider taking a heightened responsibility for patient-centered care, of which integrating behavioral health could be a key component. Expanded definitions of care coordination, disease management, and care management to incorporate both physical and behavioral health.

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
	Ensure that payment for services by more than one provider on the same day can occur, so that both a physical and behavioral health care provider can bill for services on the same patient.	Provider teams working to ensure that the right services are provided in a coordinated fashion.
	Work with academic and other training centers and national associations to create opportunities to increase knowledge and skill sets across disciplines.	Expansion of the number of providers that can support their patients' physical and behavioral health needs with evidence-based services. Training of residents and new behavioral health providers in using tools designed for implementation in an integrated setting.
Significant Redesign with Financial Incentives and Reim-bursement Structures	Recognize the shortage of primary care and realize that patients presenting at the primary care office with a variety of needs could be addressed by a behavioral health provider if so empowered. In addition, therapy codes for mental health, maternal health, and substance abuse exist that could be expanded to include behaviors related to tobacco, nutrition, exercise, sleep, pain, chronic medical conditions, and the development of self-management plans.	Integration of services results in additional brief codes being funded. The primary care provider is able to leverage the most appropriate team member for the patient and increase the efficiencies of the practice. The benefit is correctly structured into the health plan. For example, a brief smoking cessation session would not be applied to an individual's limited mental health benefit.

(continued)

TABLE 13 *(CONTINUED)*

TIER	ACTIVITIES	DESIRED OUTCOME(S)/ACTION(S)
	Ensure that primary care providers have access to timely, quality specialty mental health and substance abuse services so that patients can be moved up on the continuum of care as appropriate.	Primary care providers having timely access to psychiatric consultations via phone consultation, tele-medicine, or referral (on- or off-site).
	Ensure that psychiatrists have access to E/M codes if their responsibilities are to be expanded to include monitoring for physical conditions. For the patient with severe and persistent mental illness, they may be the only medical provider who has routine contact.	Psychiatrists being reimbursed in a manner that is consistent with their professional physician colleagues. Careful review of the health plan benefits to ensure that resources are reallocated to the E/M codes with parity.

RECOMMENDATIONS FOR HEALTH CARE DELIVERY SYSTEM REDESIGN TO SUPPORT INTEGRATED CARE

As policymakers, planners, and providers of physical and behavioral health care proceed with the steps to integrating primary care and behavioral health care, it is important to secure the buy-in of other key stakeholders in the community in order to truly redesign the health care delivery system. Policymakers can have the best vision; however, gaining traction throughout the medical community requires a multipayer and multistakeholder approach. Listed below are recommendations to consider whether *planning*, *designing*, or *implementing* a health care delivery system redesign that supports integrated care.

PLANNING

- Increase public-private partnerships by involving major players in the development of a shared vision. These include key governmental leadership, professional societies, major public and private payers, educational institutions, consumers, and provider representatives and individuals who understand complex reimbursement structures. Members of the business community and philanthropic organizations are often overlooked as important participants in this effort; their input and support should be obtained.
- Realize that jurisdictions will vary greatly in how their public programs are administered. In the event that public sector programs have contracted with commercial HMOs/MCOs, the state will need to drive contract negotiations to ensure quality standards. The National Committee for Quality Assurance (NCQA) has developed MCO accreditation standards for quality management and improvement with regards to behavioral health. The NCQA accreditation process for Medicaid health plans, though minimal, has components related to behavioral health (National Committee for Quality Assurance 2007).
- Consider a neutral entity to create a strategic plan for how primary and behavioral health care systems are integrated. For example, the Institute for Clinical Systems Improvement worked in Minnesota with medical groups, major health plans, the Department of Human Services, employer groups, and patients to create a process to fund care management and psychiatric consultation services via a bundled case rate (2008a, 2008b).

DESIGNING

- Investigate the National Council for Community Behavioral Healthcare (NCCBH), which has several tools that have been developed to assist jurisdictions in the planning and implementation stage. Its State Assessment of BH/PCP Integration Environment contains a comprehensive checklist for states (Mauer 2004).
- Encourage payers to run integrated financial data for the purpose of analysis with regards to clinical and financial outcomes. This review may identify common areas of concern and potential opportunity that can be the basis for shared objectives and can look at the issue of cost

shifting, which often occurs when one side reduces costs at the expense of the other side. For example, after running such an analysis, if multiple payers confirm that untreated substance use results in significantly higher cost in the medical benefit plan, they may opt to develop a joint plan of action.

- Utilize professional associations that are promoting the adoption of evidence-based standards of care for mental health and substance abuse in primary care for both adult and pediatric patients. For example, the American Academy of Pediatrics' *Bright Futures* publication (Hagan, Shaw, and Duncan 2008) contains many recommendations with regards to behavioral health, such as conducting a psychosocial/behavioral assessment for all ages and alcohol/drug use assessment for ages eleven through twenty-one. The work of the associations can assist the partners in keeping quality at the center of the discussion and create buy-in among providers. Consumer participation should also be secured in the development of the measures. However, adopt only the most meaningful measures so providers can move forward with clear objectives that are attainable in a timely fashion.
- Develop a shared implementation plan that is driven by data, evidence-based guidelines, and consumer input. It is likely that the financial and clinical data will drive the first phase of implementation and its ongoing monitoring.
    - Assess how current systems will perform when new services are provided by primary care and specialty mental health providers. Plan well and when possible develop consistent policy so that confusion at the provider level is reduced during implementation.
    - Walk through the model from multiple perspectives, taking into consideration state and federal policies, place of service, number of providers, authorization policies, and impact on medical visits and mental health visits. Run proactive diagnostic tests to confirm that the claim will be paid as expected. Administrators and providers become highly frustrated by denied claims. Discover and fix unanticipated financial edits contained within payment systems before going live.
- Ensure that implementation tools are designed with input from primary care providers, specialty providers, and consumers. Technical assistance and training during implementation will need to include clinical services, practice redesign, cultural competency, reimbursement, and policy. Plan for and fund the workforce necessary to train and support the primary and behavioral health providers with this substantial change in practice. Secure professional societies' endorsements and assistance in marketing, training, and communicating the clinical content.

IMPLEMENTING

- Reassure providers that integrated care is clinically beneficial and financially viable.
- Conduct technical assistance and training programs. Training needs are going to be substantial for both primary and behavioral health providers. Some will occur naturally with consultation

and integration. In addition to the training needs mentioned above, it will be crucial to adopt evidenced-based behavioral health tools designed for primary care as some primary care and specialty behavioral health providers may not be well versed in these clinical pathways. Specialty mental health providers will also need support and training to adopt evidenced-based physical health screenings.

- Identify opportunities for primary care providers to achieve the NCQA standards for a patient-centered medical home (National Committee for Quality Assurance 2008). Key components include patient tracking and registry functions, case management, adoption and implementation of evidence-based guidelines, patient self-management support, and referral tracking. Identify opportunities to ensure that these new tools incorporate and address patients' physical and behavioral health care needs.
- Set realistic timelines for project and practice implementation. A good plan may take several years to implement and should be accomplished in a thoughtful process.
- Share information with providers and other interested stakeholders when claims data and quality outcomes are measured.