Oregon Health Policy Board
Healthcare Workforce Committee
Behavioral Health Integration Subcommittee
Preliminary Survey Results

Background

The Healthcare Workforce Committee (HCWF)'s Behavioral Health Integration subcommittee distributed an online survey to gather feedback and input on one of the deliverables requested by the OHPB:

> *Deliverable #1: Identification of activities and processes necessary to achieve a foundational level of behavioral and physical health integration; highlighting of best practices seen in Oregon that are scalable.*

The survey consisted of 15 questions, broken into three major sections: 1) demographics of the survey participant's organization, 2) level of access to various types of providers within the organization (on-site, referral within the organization, external referral, or not available); and 3) status of integration based on seven elements that are foundational to successful integration of care.

Demographics of survey respondents:

The targeted respondents were physical and behavioral health care practitioners or administrators.

Survey participants self-reported as the following types of organizations (multiple responses allowed):

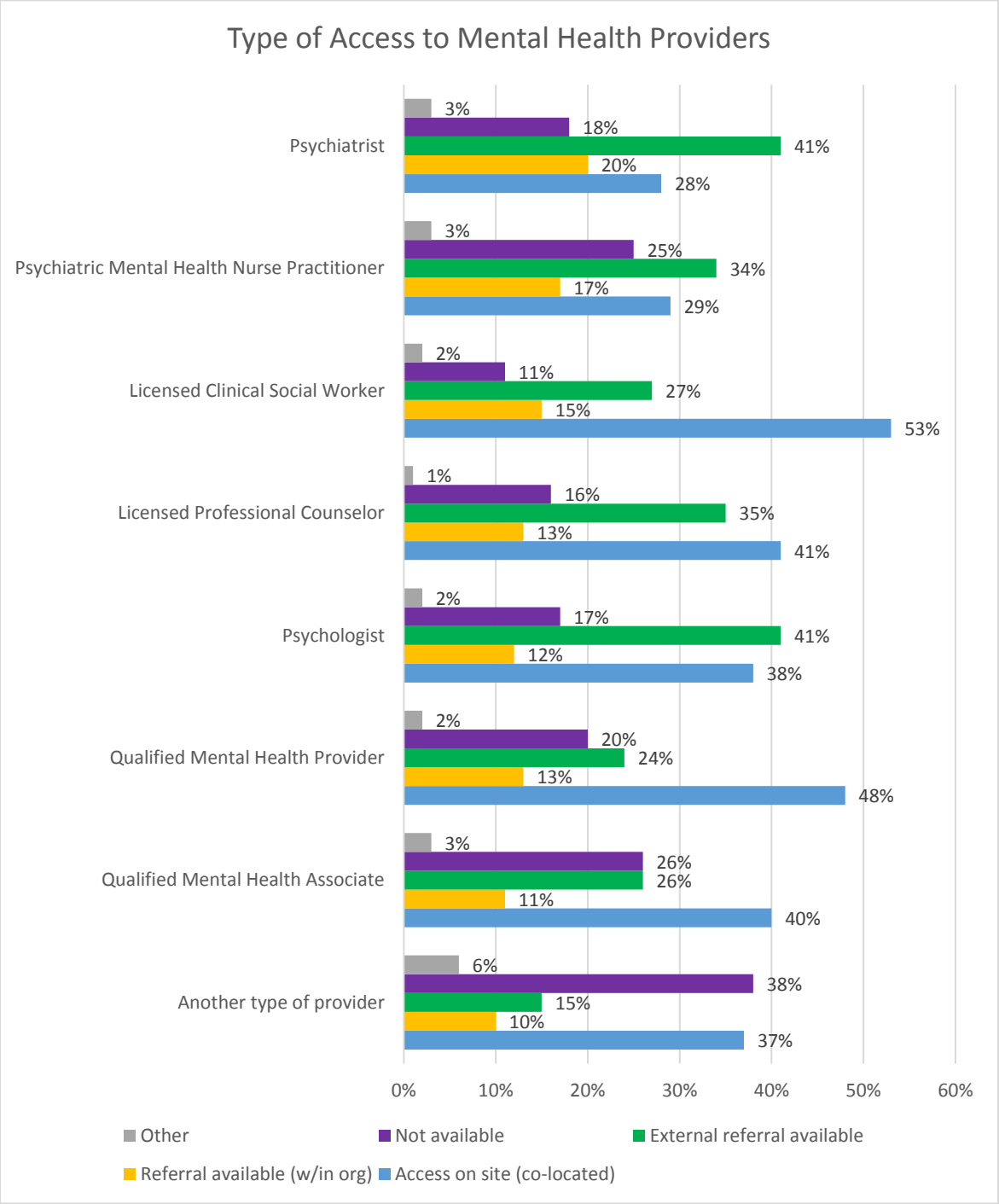
- 71 medical clinics
- 46 behavioral health clinics
- 30 small, independent practices
- 23 integrated health systems
- 15 hospitals
- 13 larger group practices
- 6 long-term care or residential facility
- 25 other (tribal; non-profit org; CCO; health district; FQHC)

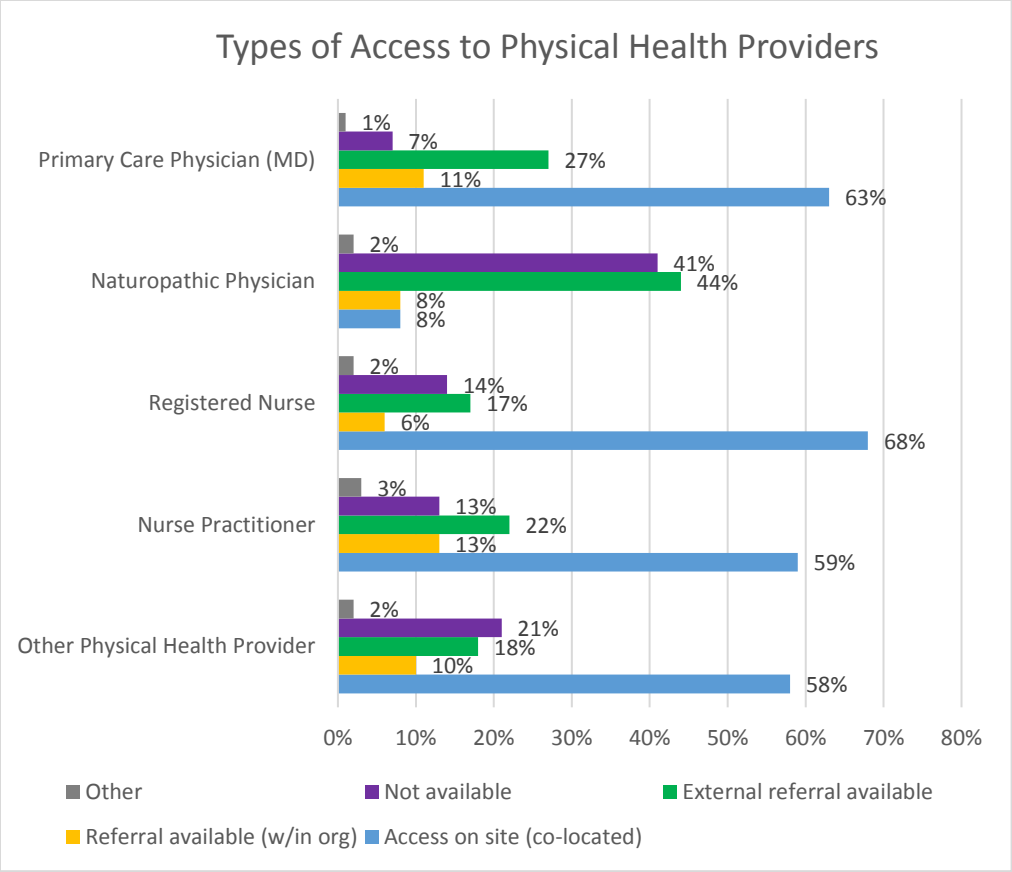
Other items of note:

- 54.3% reported as being a recognized PCPCH; 34.8% were not a PCPCH; 11.6% were unsure of their PCPCH status; and 5.5% were interested in becoming a PCPCH
- 43% defined the area surrounding their organization as rural; 47% urban; 4% frontier; 6% other
- 84% participated in CCO network(s)
- 25% employ providers who are currently receiving state- or federally-funded incentives (e.g., NHSC); 46% do not; 25% are unsure; 11% are interested in doing so
- Number of clinicians at the site ranged from 2 to 600 (multiple sites)
- Number of patients seen in January 2016 ranged from 20 to 35,000 (integrated health system)

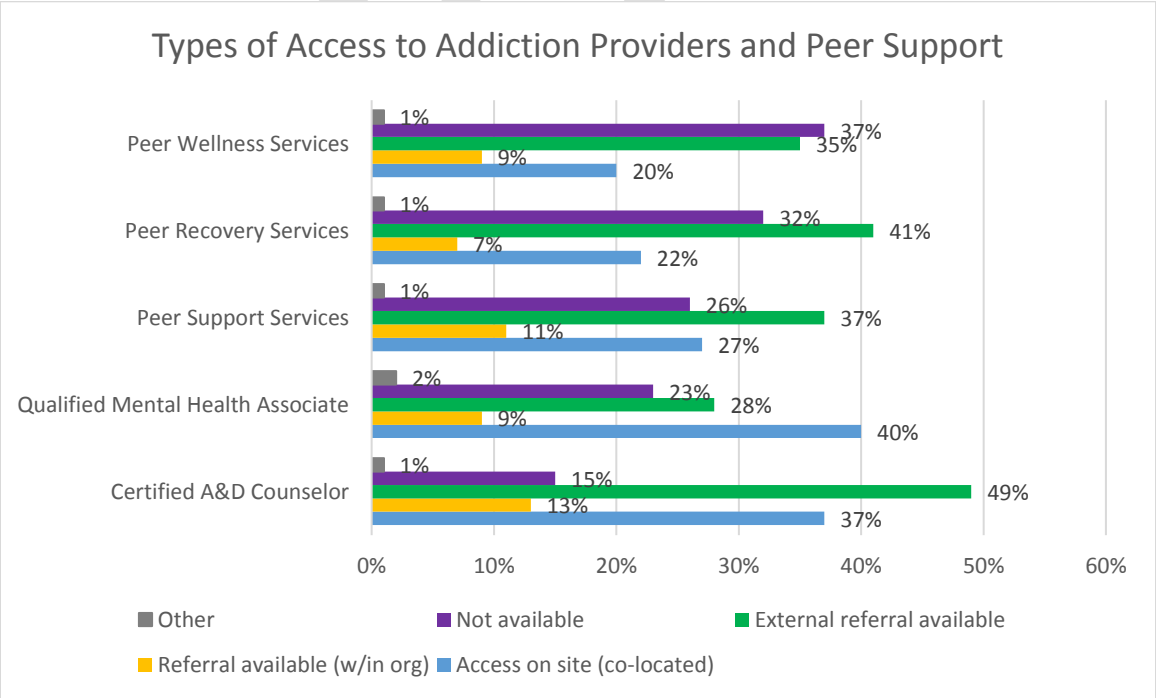
Access to Providers

Approximately one-third of respondents had **on-site** access to physical, mental, and addiction service providers (any type of provider). Nearly two-thirds reported having **on-site** access to both physical and mental health providers. Just under half of respondents had access to addictions services. If applicable, organizations were able to indicate multiple types of access available for the same type of provider.





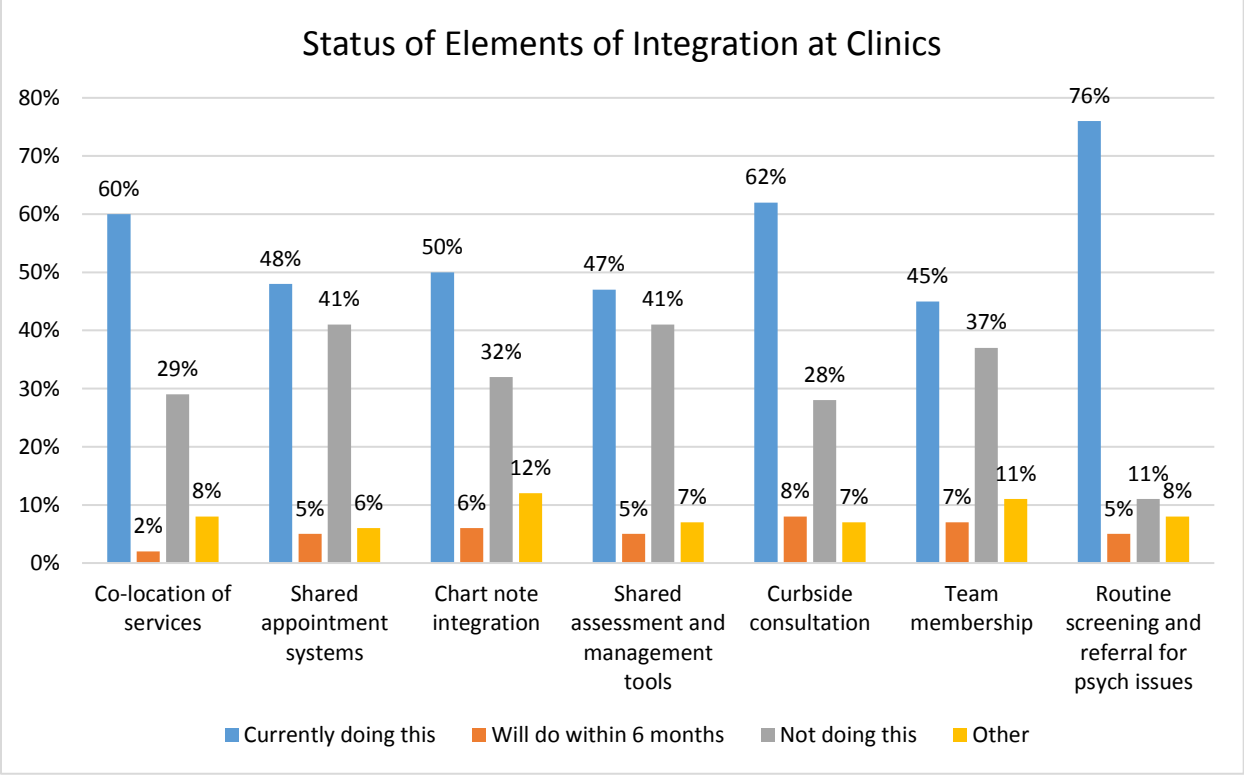
**Note: "Other physical health provider" was most commonly a Physician's Assistant*



Elements of Integration

The Health Care Workforce Committee's Behavioral Health Integration subcommittee identified seven elements/activities that are foundational for initial integration efforts between behavioral health and physical health care providers and practices.[1] The elements include:

- Co-location of services: behavioral health providers and physical health providers are all located in and provide services in the exam room area of the clinic
- Shared appointment systems: one single system is used to make behavioral health and primary care appointments for patients
- Chart note integration: behavioral health and primary care chart notes are placed in the same location/file
- Shared assessment and management tools: behavioral health providers and physical health providers use shared screens, visit templates, and outcomes instruments that are readily available (e.g., electronically or in a wall hanger folder)
- Curbside consultation: physical health providers and behavioral health providers routinely discuss patient care issues together prior to and after same-day handoffs or prior to a scheduled visit
- Team membership: behavioral health providers are regarded as core members of the primary care team and attend all primary care meetings
- Routine screening and referral for psychiatric issues: Patients are routinely screened prior to or during medical exams for behavioral health problems such as depression, PTSD, anxiety, alcohol or drug abuse



[1] Mountainview Consulting Group/Primary Care Behavioral Health – Integration Tool (2008) http://www.massleague.org/Calendar/LeagueEvents/BehavioralHealthConference/Blount-UMassPCBH-IT.pdf

Barriers to Integration Efforts

Survey respondents were asked to list the three most significant barriers they have faced in attempting to integrate behavioral health care and physical health care in their organization.

After finding consistencies among the responses, the following is a list of the top barriers identified (starting with the most commonly identified barrier):

1. **Network adequacy** (focus area: not enough mental health providers), including turnover of workforce
2. **Communication and collaboration issues**, including clarifying roles and responsibilities (power differentials) and cultural/historical issues and biases
3. **Provider education** (when to refer, type of services that each can provide), including lack of follow-up by other provider
4. **Billing** (not compensated for integrated care)
5. **Lack of space for co-location**
6. **Challenges sharing records**, which can include IT incompatibility, EMR issues and privacy/confidentiality concerns
7. **Lack of time** (to see more patients, for huddles, etc.), including scheduling (long wait times)
8. **Insurance challenges** (authorizations, network)
9. **Funding issues** (cost of BH provider, charges to clients, low or no reimbursement)

The HCWF Committee's Behavioral Health Integration subcommittee will use this list of identified barriers to further understand the challenges facing clinics interested in integrating behavioral health and primary care services. A set of policy solutions to address some of the barriers will be developed for review by the Oregon Health Policy Board in November 2016.