Aligning and Advancing Integrated Behavioral Health

Across the State of Idaho

A Stakeholder’s Report

JANUARY 2018
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The authors gratefully acknowledge the Behavioral Health Integration Stakeholder Convening participants for their time and expertise, Gina Westcott and Katie Ayad for their support in planning the convening and sharing data, and the Robert Wood Johnson Foundation for their financial support through a grant to the Farley Health Policy Center.

Suggested citation
Background

Idaho is redesigning its healthcare system with a state innovation model grant from the Center for Medicare and Medicaid Innovation. The goals of Idaho’s State Healthcare Innovation Plan (SHIP) are to improve Idahoans’ health by strengthening primary and preventive care through the patient centered medical home (PCMH), and evolve from a fee-for-service, volume-based payment system of care to a value-based payment system that rewards improved health outcomes [1].

Whole person, patient-centered care requires meeting both physical and behavioral health needs. The separation of physical and behavioral health is costly and results in poorer health outcomes. With PCMH transformation efforts underway with SHIP and previously in the Medical Home Collaborative, there are opportunities to better integrate behavioral health.

The Farley Health Policy Center (FHPC) advances policy to integrate systems that address the wholeness of a person, their physical, behavioral and social health in the context of family, home, community and the healthcare system. The FHPC works with states to understand achievable policy actions to improve the integration of behavioral health across health and healthcare systems. With support from the Robert Wood Johnson Foundation, the FHPC partnered with the Idaho Department of Health and Welfare-Division of Behavioral Health to provide assistance to advance integration of behavioral health in Idaho. Through a series of conversations to better understand current efforts and needs, the FHPC and Division of Behavioral Health began planning for a stakeholder convening with the aim to align a statewide vision for integrated care and to identify action steps for moving forward collectively.

The Division of Behavioral Health organized the participant invitee list, starting with stakeholders from the Idaho Healthcare Coalition and the State Healthcare Innovation Plan (SHIP) Behavioral Health Integration Workgroup. To gather input from stakeholders and prepare for the convening, invited participants received an online survey to help develop the proposed vision, define current barriers and assets to integrating behavioral health, and values to guide effective integration. Respondents were also asked to review and provide additions to a list of stakeholders in Idaho working on integrating care. Survey responses were synthesized and presented in aggregate at the convening. Findings shaped the goals for the day and guided content for the discussions.

Data from Medicaid’s fee-for-service claims database and from Optum’s Idaho Behavioral Health Plan (fiscal year 2016) were analyzed to establish a baseline understanding of behavioral health services in Idaho and to inform the convening’s discussion. Behavioral health diagnoses for analysis included mental health disorders and substance use disorders. See Appendix A for data analysis methods. These data were presented at the convening, providing a broad overview of the epidemiology of behavioral health among Idaho’s Medicaid population to inform how integration efforts may be directed to those in need of behavioral health services.
The stakeholder convening was held on Thursday, November 9, 2017 in Boise, Idaho. The convening agenda and list of participants are found in Appendix B and C. In addition to the participant survey and behavioral health data, presentations included cost and clinical outcomes of integrated care and best practices for operationalizing integration. Breakout sessions focused on community and state strengths and gaps; prioritization of activities; and building relationships among participants for future work to advance behavioral health integration across Idaho.

This report describes the survey and claims data collected and analyzed, as well as the discussion and action items prioritized during the convening.

Vision and Values

The following vision statement and values were written and tailored to reflect the specific input collected from Idaho state leadership and convening participants:

Vision: All Idahoans are able to receive affordable and quality care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.

Values:

• Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services across the state, including rural and frontier areas.
• Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
• Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
• Providers sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
• Organizations and providers should remain open to innovation and collaboration to best meet the needs of patients and families.

Behavioral Health Data

In 2015, more than 43 million Americans experienced a mental health issue, 20.8 million experienced a substance use disorder, and 8.1 million experienced both [2]. Within the healthcare delivery system in 2014, there were 65.9 million visits to physician offices and 5 million emergency department visits for patients with a primary diagnosis of a mental health disorder [4, 5]. Additionally, there has been a staggering increase in the age-adjusted rate of suicide, up 24% from 1999 to 2014 [3].
At the state level, 20% of Idahoans experienced a mental health issue which is slightly higher than the national prevalence of 18% [4]. With regard to substance use, 8.1% of Idaho’s adult population reported substance dependence or abuse, equivalent to the national prevalence in 2014-15 [4]. Over a third (37%) of adults in Idaho self-reported having poor mental health status. Thirty-three percent of Idaho’s overall population is low-income [5], a well-documented risk factor for behavioral health issues and a barrier for healthcare access.

Insurance coverage is an important marker of behavioral healthcare access. Figure 1 shows the distribution of health insurance coverage in Idaho for 2015; 48% of the population was covered by employer-based insurance, 18% Medicaid, 14% Medicare, 11% uninsured, 8% non-group, and 1% other public insurance. From 2013 to 2015, the uninsured rate for Idaho decreased from 15% to 11%, corresponding with the implementation of the Patient Protection and Affordable Care Act (ACA). Medicaid/CHIP enrollment also increased in Idaho since the implementation of the ACA.

**Figure 1. Health Insurance Trends in Idaho [5]**

**Medicaid’s Role in Behavioral Health**
As the single largest payer in the United States for behavioral health services, including both mental health and substance use services, Medicaid plays a critical role in the integration of behavioral health. In 2009, Medicaid accounted for 26% of behavioral health spending in the United States [6].

While one in five Medicaid beneficiaries had behavioral health diagnoses, they accounted for almost half of total Medicaid expenditures in 2011, with more than $131 billion spent on their total cost of care [6].

**Medicaid – State of Behavioral Health in Idaho**
In fiscal year 2016, 277,657 Idahoans were enrolled in Medicaid (22.1% of the total state population). Medicaid spending totaled $2.1 billion in 2016, and 1 in 6 dollars spent overall in
the health system was in Medicaid. According to the Kaiser Family Foundation, 16% of the state general fund spending in Idaho is for Medicaid and 46% of all federal funds received by Idaho are for Medicaid. Almost all (93%) of Medicaid beneficiaries in Idaho are in primary care case management [5]. Behavioral health services are carved-out in a managed care plan managed by Optum, the Idaho Behavioral Health Plan. This plan does not include inpatient behavioral health services.

For FY 2016, within fee-for-service (FFS) claims, 108,185 (39%) Medicaid members had either primary or secondary behavioral health diagnoses. Among Medicaid managed care enrollees in the Idaho Behavioral Health Plan (IBHP), 49,970 (17%) had primary or secondary behavioral health diagnoses. With an average of 301,458 IBHP members with a Medicaid benefit, only 29,507 Medicaid members utilized IBHP behavioral health managed care services. This means fewer than 10% of IBHP members with a Medicaid benefit utilized behavioral health managed care services. Thus, there is a significant opportunity to address this discrepancy between need for behavioral health services and access to behavioral health care. Nearly eight percent (7.7%) of members with a primary or secondary behavioral health diagnosis in the FFS model were diagnosed with serious mental illness (SMI), defined as having bipolar disorder, schizophrenia, or other psychotic disorders; while for the managed care model, 16% of members were diagnosed with a SMI as either their primary or secondary diagnosis. The need for both physical and behavioral health services for those with diagnosed SMI requires acute attention to access and coordination of care.

Regarding expenditures, $387 million was spent in FY16 on FFS members with behavioral health diagnoses, which accounts for 27.6% of total FFS costs. Figure 2 describes the services that make up the cost of claims for these Medicaid members. Nearly half are outpatient services (including 12.3% for home health; 6.4% for office-based; 8.2% for school-based; and 0.4% for emergency services); 19% to pharmacy; 12% each to residential and intermediate treatment; 9% to inpatient services; and 1% to other costs including medical equipment, labs, and radiology.

![Figure 2. Sites of Service for FFS Behavioral Health Claims, FY16.](image-url)
Figure 3 shows the annual cost per member by region and stratified by FFS and managed care organization (MCO) claims, and by severity of disease defined as SMI or non-SMI (MCO denotes the Idaho Behavioral Health Plan). Because the data used for this analysis comes from two different de-identified sources, the number of members that overlap between FFS and MCO data is unclear. This figure is intended to demonstrate cost variation by region and severity of illness rather than direct comparison between FFS and MCO data.

Collating data from multiple, fragmented sources creates challenges for data management and analysis. Integration of systems to align data collection and measures is essential in addition to integration of payment and delivery systems.

For more detailed results of these analyses, refer to Appendix D for additional tables and figures. See the Tools and Resource section of this report for a link to an interactive, online map of behavioral health data in Idaho.

**Barriers and Assets to Integrating Behavioral Health**

Efforts to better integrate care are happening across the nation and across Idaho. The transformation of care delivery to address both physical and behavioral health conditions is supported by a variety of assets and innovations in Idaho, while simultaneously hindered by existing barriers including fragmentation of payment models. The barriers and assets to integrating behavioral health identified by convening participants are listed below, organized by domain.
Organizing the movement

Barriers: A driving force to hold this stakeholder convening was the identified challenge that although there are multiple entities in the state of Idaho focusing on increased access to behavioral health services, many are currently working in isolation, without a shared understanding of common goals or current work. Influential partners often do not know how to connect and align their efforts, resulting in redundancies and potentially missed opportunities, both at a community and policy level. This convening allowed for some of those communication gaps to be identified and acknowledged, with a commitment to improved collaboration moving forward.

Assets: Idaho’s SHIP has provided tremendous opportunity to transform care, including behavioral health. SHIP has provided recognition of the importance of integrated behavioral health as well as the structure to advance transformation. Additionally, stakeholder engagement and commitment to meeting behavioral health needs through better integrated care is an asset. While there is an issue of efforts and organizations working in isolation in areas, there are also many great community partnerships across disciplines and public and private entities. A complete list of stakeholders identified through the online survey, at the convening, and by the Division of Behavioral Health can be found in Appendix E. Stakeholders include primary care and behavioral health providers and educators, healthcare systems, and agencies and organizations such as the Idaho Department of Health and Welfare and the Idaho Primary Care Association. Participants identified the fact that policy and decision makers are aware of the need to improve behavioral health care, and are poised for change, is an asset.

Workforce, education, and training

Barrier: There is widespread agreement both nationally and in Idaho that the current clinical workforce lacks sufficient diversity, appropriate geographic distribution, and opportunity for inter-professional education and development. There is an immediate need to create and support professional development programs to enable psychologists, social workers, counselors, nurses, physician assistants, physicians, and others to work in integrated settings with a clear understanding of roles and competencies. Stakeholders identified the shortage of behavioral health providers, low pay for primary care and behavioral health providers, and difficulty engaging with primary care providers as challenges to advancing integrated care.

Assets: Academic training programs, like the Family Medicine Residency of Idaho, Boise VA Medical Center primary care psychology postdoctoral program, Boise VA nurse practitioner residency program, University of Washington internal medicine residency – Boise, and the University of Washington psychiatry residency program – Idaho advanced clinician track, provide exposure to and incorporate behavioral health into general medical settings. Local training programs help grow a workforce more likely to stay within the state and prepared to work in integrated settings. A new asset identified by stakeholders is the Idaho Integrated Behavioral Health Network, a newly developed learning collaborative designed to support the growth of integrated behavioral health programs and to assist in team-based care management.
of co-morbid medical and behavioral health conditions in primary or specialty care clinics. The learning collaborative develops networking and clinical training opportunities for behavioral health providers and advocates for best practices of integrated care.[7]

**Financing**

*Barriers:* Both nationally and locally in Idaho, achieving integration is slowed by financial arrangements that separate out mental and physical health benefits, payments, and services. Fractured payment systems have made it difficult to build and sustain primary care practices with integrated behavioral health providers. There are ongoing efforts with payers in Idaho to better understand the value of behavioral health integration and institute changes in payment models to create an environment where primary care can financially sustain behavioral health services; however, this remains a significant challenge.

Within the current FFS model, there is a lack of sufficient billing codes to support integration. Though convening participants expressed optimism that new codes may become available as soon as 2018, currently participants believe that there are limited billing codes available to support behavioral health services in primary care.

*Assets:* Although financing was the top barrier identified by convening participants, a few innovations in payment support for integrated behavioral health were highlighted, including new, albeit limited, insurance payment for tele-psychology, Optum’s support of newer integrated codes as mentioned above, development of Regional Care Organizations, and Medicaid Healthy Connections tiered payments which include behavioral health integration as an option qualifying for a higher payment tier.

**Technology**

*Barriers:* Even in places where technology can enable the exchange of behavioral health data, it is not being used to its full capacity. Extreme privacy practices around behavioral health are often driven by misunderstandings, inconsistent legal interpretations, lack of education of clinical and administrative staff, and conservative legal interpretations by provider organizations, all leading to the inability to coordinate and integrate care.[8] Again, Idaho mirrors these nationally identified challenges. Regulations related to data sharing about behavioral health services have been interpreted in multiple ways, and many providers expressed that they do not have clear guidance on how and with whom it is appropriate to share behavioral health notes, diagnoses, and treatment plans.

*Assets:* One of the main goals of the SHIP is to improve care coordination through the use of EHRs and health data connections among patient-centered medical homes (PCMHs) and across the medical neighborhood. The Idaho Health Data Exchange (IHDE) provides a platform for data sharing, and together with SHIP, has been connecting more practices across the state. While challenges with behavioral health data sharing remain, IHDE has been requested to provide educational support, and demystify and offer guidance for sharing data.
Care delivery

**Barriers:** Primary care practices are integrating behavioral health to help overcome barriers due to lack of access and the stigma of seeking and receiving behavioral health care. Some providers acknowledge feeling overwhelmed with the practice transformation necessary for team-based, integrated care. Practices identified the need for technical assistance and resources to help operationalize integrated care. Other challenges include needing support for referrals and transitions of care when integrating within a practice is not feasible.

**Assets:** There are many efforts across the state to integrate behavioral health into primary care. Stakeholders recognized the work of integration leaders: Family Medicine Residency of Idaho, Terry Reilly and other FQHCs, St. Luke’s Health Partnerships, Saint Alphonsus, and Lifeways. Additionally, many endorsed that efforts through SHIP and earlier in the Medical Home Collaborative have spread the PCMH model, laying a foundation of advanced primary care with more capacity for integration. Other efforts to improve behavioral health in Idaho include the work of organizations in the non-profit community such as the Suicide Prevention Action Network of Idaho, Idaho Voices for Children, mental illness intensive care programs, mental health crisis centers, and peer support programs.

Population and community health

**Barriers:** Integrating behavioral health care is a strategy to meet behavioral health needs and support the health of broad and discrete populations. Coordinating systems for data collection around clear adult and pediatric behavioral health measures and having defined metrics and benchmarks for achieving improved and equitable care are challenges for all states, including Idaho. Disparities in access to care in frontier and rural areas, as well as the lack of Medicaid expansion and the resulting coverage gap were identified as significant barriers.

**Assets:** Stakeholders recognized the role of agencies and organizations in addressing behavioral health needs, convening stakeholders, and leading innovative partnerships to advance integrated behavioral health to improve population health. Among those highlighted, the Department of Health and Welfare Divisions of Behavioral Health, Medicaid, and Public Health, Regional Behavioral Health Boards, and the Public Health Districts were named. Additionally, a recent grant awarded to Idaho Voices for Children focuses on consumer advocacy for transformation as a strategy to develop and incorporate a permanent consumer voice and community home for health systems change.

Opportunities to Advance Integration

After indexing current barriers and assets, convening participants identified short term (3-6 months) opportunities to advance integrated care in Idaho. These opportunities were discussed in small groups and reported out to all participants. Each individual then voted on their top two priorities for action from the collated list of reported suggestions. The following synthesis highlights opportunities identified as priority action areas.
Organizing the movement
Having a shared language among all stakeholders is an important precursor for change. Currently, different stakeholders use different definitions and have different understandings of integrated care. Without a shared definition, creating unified strategies for payment reform, workforce, education, and care delivery to achieve and scale integrated care can be challenging.

- Create a shared definition for integrated behavioral health in Idaho. Leverage existing definitions (i.e., AHRQ Lexicon for Integrating Behavioral Health and Primary Care) and expand or adapt to reach consensus on a shared definition for Idaho’s efforts to integrate care, including the role of integration in hospitals and primary care working in specialty mental health.
- Use SHIP efforts as a platform to disseminate educational materials to begin using a shared definition.

Achieving and advancing integrated care requires committed stakeholders to champion the cause. Convening participants demonstrated the dedication, passion, and expertise to advance the work of integrating care.

- Build collaboration with this stakeholder group and SHIP Behavioral Health Integration Workgroup to continue multi-stakeholder conversations and act on recommendations.
- Assess stakeholder engagement and recruit missing stakeholder groups to fill any gaps to ensure sufficient representation from primary care, patients and community members, universities, and training programs in addition to local and state public health and government agencies.

Workforce, education, and training
Efforts to train the existing workforce and educate the upcoming workforce are critical to Idaho’s integrated care efforts.

Current workforce

- Educate primary care providers on the value of integrated care and the scope of health conditions behavioral health providers can address, including mental health diagnoses, substance use disorders, and health behavior change.
- Provide assistance to primary care providers to understand the type of behavioral health provider needed to meet their patients’ behavioral health needs. Encourage behavioral health providers to follow up with primary care providers on psychiatry referrals to assess whether appropriate for specialty mental health, or if the patients’ needs could be met in the primary care office with an integrated behavioral health provider.
- Partner with Optum to train behavioral health providers to understand the broader healthcare continuum and role of integrated services.
- Build learning communities among providers to share best practices and tactics for overcoming challenges. Explore the mentorship program within SHIP and peer-to-peer mentoring with Idaho Integrated Behavioral Health Network as opportunities to grow learning communities.
• Conduct a workforce assessment to describe the current behavioral health workforce. Assess behavioral health needs to understand where workforce distributions (across regions and settings) may be needed as a means to better address the gap between identified behavioral needs and access to services.
• Assess where current integrated care providers are educated and trained to inform opportunities for recruitment and training the future workforce to provide integrated care.

**Future workforce**
• Within the WWAMI states (Washington, Wyoming, Alaska, Montana, and Idaho), advocate for PCMH training to include behavioral health.
• Support the state legislature’s current consideration of increased funding for residencies and training sites for behavioral health professionals. Explore better reimbursement for trainees.
• Assess Idaho’s medical and behavioral health training programs and advocate for tracks or education pathways to prepare an integrated care workforce. Learn about current efforts underway to include team-based care in accreditation standards and align support.
• Create partnerships with the VA Center of Excellence and leverage the innovations emerging from the training sites.

**Financing**
Financing is often identified as the biggest barrier to delivering integrated care. While efforts to fully reform the payment system to support integrated care delivery are needed to scale efforts, participants identified the following actions to achieve iterative, short-term success in financing integrated care.
• Provide opportunities for payer-led education for providers on available billing codes for integrated care, how to better utilize existing funding in the system, and current value-based payment models.
• Convene payers to align incentives and measures for integrated care.
• Inform payers of the business case for integrated care and assist practices in developing their specific case to present to payers.
• Examine other state strategies to adjust payment policies and reimbursement criteria, such as evolving models of behavioral managed care organizations that differentially cover behavioral health services in primary care and specialty settings.

**Technology**
There is a need for information to be shared across provider types and settings to support integrated care. Although the infrastructure may exist to advance data sharing, efforts to improve understanding of what is allowable is needed.
• Partner with Idaho Health Data Exchange to educate providers on data sharing, including the state statute on psychotherapy versus progress notes.
• Assess how telehealth dollars are being spent and how resources can be maximized.
• Leverage Project ECHO as a platform to spread telehealth.
• Advocate for reimbursement of telehealth provided by non-prescribing behavioral health providers.

**Care delivery**

There are many practices and health systems across the state restructuring their care delivery to provide integrated care. Building on these innovative practices provides an opportunity to scale efforts.

- Create opportunities to access technical assistance, practice facilitators, integration experts, and resources to operationalize integrated care, including on successful business models, how to use data, and competencies for integrated practices and providers.
- Educate providers to use data to understand and assess behavioral health needs within their patient population. If access to the necessary data is lacking, work with state agencies and payers to increase access to current data.
- Explore opportunities to leverage practice efforts to obtain PCMH recognition to focus on behavioral health.
- Develop care compacts between specialty mental health and primary care to establish shared understanding of roles for meeting behavioral health needs, referral standards, and plans for information exchange. Have regular meetings to facilitate collaboration and build a robust bi-directional referral system.

**Population and community health**

Integrating behavioral health and primary care increases access to behavioral health services at a population level. Additional efforts to integrate across other sectors (such as schools and the justice system), partner with community organizations, and incorporate the patient and community voice in planning can further meet behavioral health needs in the state.

- Educate patients and families to understand the benefits of integrated care.
- Explore opportunities to integrate behavioral health in other settings including schools, correctional facilities, and hospitals.
- Involve patients and families in stakeholder convenings and other planning efforts to advance integrated care.
- Partner with community organizations to understand and meet behavioral health needs. Leverage current opportunities, like Idaho Voices for Children’s grant from the Robert Wood Johnson Foundation, to address gaps in behavioral health access and integrate care.
Next Steps

Of the short-term opportunities listed above, the following areas for actions emerged as the top priorities:

**Organizing the movement**
Create and use a shared definition of integrated care

- Create a shared definition of integrated behavioral health to be used across integration efforts in Idaho.

**Workforce, education, and training**
Train the current workforce and improve the pipeline for integrated care

- Educate primary care providers on the value of integrated care, the scope of health conditions behavioral health providers can address, and how to identify the type of behavioral health provider needed to meet their patients’ behavioral health needs.
- Build learning communities among practices and providers to share best practices and tactics for overcoming challenges.
- Assess Idaho medical and behavioral health training programs and advocate for tracks and education pathway to prepare an integrated care workforce. Learn about current efforts underway to meet accreditations standards and align support.

**Financing**
Optimize payment for integrated services within the current system

- Provide opportunities for payer-led education for providers on current billable codes for integrated care, how to better utilize existing funding in the system, and understand payers’ value-based payment.
- Examine other state strategies to adjust payment policies and reimbursement criteria, such as evolving models of behavioral managed care organizations that differentially cover behavioral health services in primary care and specialty settings.

**Care delivery**
Support practice transformation with resources and expertise

- Create opportunities to access technical assistance, practice facilitators, integration experts, and resources to operationalize integrated care.
Tools and Resources

Idaho Behavioral Health Mapping Tool
The Farley Center created an interactive mapping tool to better understand behavioral health in Idaho. The map compiles population health outcomes, behavioral health services utilization, and access data from the Divisions of Medicaid, Public Health and Behavioral Health within the Idaho Department of Health and Welfare. Users can map the variables that they would like to compare by region, including the location of providers and services, prevalence of diagnoses, population demographics, and behavioral health outcomes. Idaho Mapping Tool: https://arcg.is/KuXGi

Eight Core Competencies for Behavioral Health Providers Working in Primary Care
This resource details competencies for onsite behavioral health providers as members of the primary care team in highly integrated practices. Make Health Whole is a communications platform dedicated to advancing whole-person, integrated health. Additional resources will be added to the site in 2018. https://makehealthwhole.org/

The Integration Playbook
The Playbook is a guide to integrating behavioral health in primary care and other ambulatory care settings. The Playbook’s implementation framework is meaningful to organizations at any stage of integration development and of any size. More resources on integrated behavioral health can be found on the AHRQ Academy Portal. https://integrationacademy.ahrq.gov/playbook/about-playbook

Advancing Care Together by Integrating Behavioral Health and Primary Care
Journal of the American Board of Family Medicine – Supplement
This journal supplement draws lessons and evidence from 19 integrated behavioral health and primary care practices. The articles can be extracted according to a reader’s particular interest, but taken together contribute to an emerging picture of complexity, challenge, success, and struggle during the journey to integrate primary care and behavioral health. They are about the “how” of integrated behavioral health and primary care. http://www.jabfm.org/content/28/Supplement_1

From Our Practice to Yours: Key Messages from the Journey to Integrated Behavioral Health
Innovators integrating behavioral health and primary care share key messages and insight from their practical experiences for use by other practice leaders to accelerate their practice transformation to integrated care. http://www.jabfm.org/content/30/1/25.full

Outcomes of Integrated Behavioral Health with Primary Care
This article presents quantitative and qualitative data from patients with depression receiving care in integrated primary care practices. http://www.jabfm.org/content/30/2/130.full
Creating a Culture of Whole Health
This report provides actionable recommendations to begin to scale and spread the integration of behavioral health from more than 70 key informants, focus group participants, and a working meeting of national leaders.
http://farleyhealthpolicycenter.org/cultureofwholehealth/
References


Appendix A. Behavioral Health Data Analysis Methods

The Farley Health Policy Center received data from three divisions within the Idaho Department of Health and Welfare: the Division of Medicaid, Division of Public Health, and the Division of Behavioral Health. The following is a list of specific data sources from each department:

- **Division of Medicaid**
  - Idaho Medicaid FFS claims data, FY16
  - Optum’s Idaho Behavioral Health Plan managed care encounter data, FY16

- **Division of Public Health**
  - Idaho Vital Statistics, Bureau of Vital Records and Health Statistics
    - Birth and Mortality Rates, 2015
    - Pregnancy Risk Assessment Tracking System, 2015

- **Division of Behavioral Health**
  - Geographic Data on
    - State Mental Health Hospitals
    - State-Funded Behavioral Health Facilities

For the FFS claims and Idaho Behavioral Health Plan encounter data analyses, the diagnoses, prescription classes and place of service codes used are defined using standard classification methods. The Agency for Healthcare Quality’s Healthcare Cost and Utilization Project Clinical Classifications Software (CCS) was used to categorize diagnostic codes from primary or secondary diagnosis listed on the Medicaid claim [9]. The following CCS codes were used to classify behavioral health diagnoses:

<table>
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<tr>
<th>HCUP CCS Categories</th>
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<tr>
<td>'650' Adjustment disorders</td>
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<tr>
<td>'651' Anxiety disorders</td>
</tr>
<tr>
<td>'652' Attention-deficit conduct and disruptive behavior disorders</td>
</tr>
<tr>
<td>'653' Delirium dementia and amnestic and other cognitive disorders</td>
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<tr>
<td>'654' Developmental disorders</td>
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<tr>
<td>'655' Disorders usually diagnosed in infancy childhood or adolescence</td>
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<tr>
<td>'656' Impulse control disorders NEC</td>
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<tr>
<td>'657' Mood disorders</td>
</tr>
<tr>
<td>'658' Personality disorders</td>
</tr>
<tr>
<td>'659' Schizophrenia and other psychotic disorders</td>
</tr>
<tr>
<td>'660' Alcohol-related disorders</td>
</tr>
<tr>
<td>'661' Substance-related disorders</td>
</tr>
<tr>
<td>'662' Suicide and intentional self-inflicted injury</td>
</tr>
<tr>
<td>'663' Screening and history of mental health and substance abuse codes</td>
</tr>
<tr>
<td>'670' Miscellaneous mental health disorders</td>
</tr>
</tbody>
</table>
Prescriptions for Behavioral Health conditions were classified using First Databank’s Hierarchical Specific Therapeutic Class Code (HIC-3), which is a component of the National Drug Data File [10]. The treatment setting for claims are classified using the Centers for Medicare and Medicaid’s Place of Service Codes for Professional Claims [11].

For the data from the Division of Medicaid, unique member counts were calculated from encounter and claims data and aggregated by Idaho Public Health Districts [12] prior to receipt by FHPC. Descriptive analyses were conducted to describe Medicaid members or the number of services. Fee-for-service claims and Optum’s managed care organization (MCO) encounter data were analyzed separately. Because Medicaid beneficiaries can be enrolled in both the fee-for-service and Optum’s Idaho Behavioral Health Plan, aggregate-level data cannot differentiate whether an individual was counted in both models; therefore, descriptive statistics are not directly comparable.

While Medicaid utilization and cost data are vital components to understanding behavioral health services, particularly in rural areas where Medicaid is the only payer for behavioral health, our analyses are limited in understanding of trends and distribution of behavioral health in the non-Medicaid population. Although some information can be extrapolated to generalize trends, additional payer data and integrated data collection would provide a more comprehensive picture.

For the Division of Public Health data, descriptive statistics were calculated and aggregated to the Public Health Districts. Geographic data from the Division of Behavioral Health was collected, geocoded and mapped into ArcGIS® software by Esri (Copyright © Esri [13]). These data were used to create the mapping tool for Idaho Behavioral Health data.
Appendix B. Idaho Behavioral Health Stakeholder Convening Agenda

Behavioral Health Integration Stakeholder Convening
Thursday, November 9 | 9:30am-2:30pm | Boise, ID

Convening purpose:
To define a common vision for behavioral health integration in Idaho

Desired outcomes:
- Shared understanding of current practices, efforts and initiatives across the state to integrate behavioral health
- Stakeholder input on the values and priorities that shape an integrated behavioral health system
- Established agreement and variation of the assets and barriers to integrating behavioral health
- Stronger relationships between stakeholders working on these issues across the state
- Delineated next steps that bring stakeholders together

Vision, developed from survey responses:
All Idahoans may seek and receive affordable care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.

Values, identified from survey responses:
- Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services.
- Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
- Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
- Clinicians sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
- Organizations and clinicians should remain open to innovation and collaboration to best meet the needs of patients and families.

Agenda:
9:30am Welcome and introductions Gina Westcott
9:45am What we’ve learned: Survey results and behavioral health data Shale Wong, MD, MSPH Lina Brou, MPH
10:45am Break
11am Breakout session: Strengths, gaps, and building relationships
12pm Networking lunch
1pm Operationalizing integration Jonathan Muther, PhD Stephanie Kirchner, MSPH, RD Shale Wong, MD, MSPH
2pm Integrating together
## Appendix C. Stakeholder Convening Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Agency</th>
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<td>Lina Brou, MPH</td>
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<td>Christine Tiddens</td>
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<tr>
<td>Marilyn Sword</td>
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<td>Susan Ault</td>
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<td>Jann Stockwell</td>
<td>Sr. Communications Specialist</td>
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<td>Sara Bartles</td>
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<td>India King</td>
<td>Associate Director</td>
<td>Veterans Administration</td>
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Appendix D. Additional Behavioral Health Data Results

In the fee-for-service data, 42% of FFS members had pharmacy claims for BH medications. 19.1% of all pharmacy expenditures go to BH prescriptions, which totals $74.3 million. The following figure describes the distribution of behavioral health prescriptions:

Figure A2. Distribution of BH prescriptions for FFS members

Figure A3 shows the age distribution of the 49,970 members who were enrolled in the Optum Idaho Behavioral Health Plan (MCO) and 108,185 members within FFS in FY16. This figure shows that the MCO members who receive outpatient services under the Idaho Behavioral Health Plan tend to be less than 18 years of age. Given that MCO members may also receive inpatient and pharmacy services within the FFS delivery model, the difference in distributions should be interpreted with caution.
See the Tools and Resources section for information on an interactive mapping tool that compiles data from three divisions within the Idaho Department of Health and Welfare. Figure A4 displays example maps using the data collected from the Division of Public Health.
Appendix E. Behavioral Health Integration Stakeholders

A list of behavioral health integration stakeholders identified by convening participants:

- Blue Cross of Idaho
- Boise State University
- BPA Health
- Business Psychology Associates (now known as BPA)
- CASA
- Clearwater Medical Lewiston
- Consortium for Idahoans with Disabilities
- Dept of Health and Welfare-Behavioral Health
- Dept of Health and Welfare-Medicaid
- Dept of Health and Welfare-Office of Health Policy
- Dept of Health and Welfare-Office of Suicide Prevention
- Dept of Health and Welfare-Public Health
- El Centro de Comunidad y Justicia
- Empower Idaho
- Family Health Services in Twin Falls
- Family Medicine Residency of Idaho
- Farley Health Policy Center
- Head Start
- Health Management Associates
- Health West Pocatello
- Heritage Health
- Human Supports of Idaho
- Idaho Academy of Family Physicians
- Idaho Academy of Physicians
- Idaho Association of Counties
- Idaho Commission on Aging
- Idaho Federation of Families for Children’s Mental Health
- Idaho Healthcare Coalition
- Idaho Hospital Association
- Idaho Integrated Behavioral Health Network
- Idaho Primary Care Association
- Idaho Psychological Association
- Idaho Voices for Children
- Journey Mental Health
- Kootenai Health Network
- Kootenai Residency
- Kootenai Behavioral Health
- Lifeways
- Nampa Schools
National Alliance on Mental Illness - Upper Valley Idaho
Northpoint Recovery
Northwest Telehealth Resource Center
Optum Idaho
Pacific Source
Pioneer/Pathways
Public Health Districts
Public Health Executive Directors
Regence
Regional Behavioral Health Boards
Regional Health Collaboratives
SAGE Health Care
Saint Alphonsus Behavioral Health
Shoshone Medical Clinic / Shone Family Medical Center
Suicide Prevention Action Network of Idaho
Terry Reilly Health Services
University of Idaho
Valley Family Health Care (FQHCs)
Valley Medical Lewiston
Veteran’s Administration / VA Medical Center
Warm Springs Counseling
Women’s and Children’s Alliance in Boise