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Case Studies of Three Policy Areas and Early State Innovators: 2014 State Profiles

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2014 State Profiles

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 1
Strategic Policy Areas 1
Lessons Learned 2
INTRODUCTION 5
Background 5
Purpose of This Report 6
METHODOLOGY 7
Selection of States 7
Interview Modules 8
Interviews With States 9
SUMMARY OF FINDINGS 10
State Activities to Implement Evidence-Based Practices 10
State Activities to Improve Behavioral Health Business Practices 20
State Activities to Integrate Behavioral Health With Physical Health Services 24
CONCLUSIONS 29
APPENDIX A: CASE STUDIES ON THE IMPLEMENTATION OF EVIDENCE-BASED PRACTICES 30
District of Columbia 30
Maryland 35
Massachusetts: Bystander Naloxone Distribution Program Preventing Fatal Opioid Overdose 40
Missouri: Medication-Assisted Treatment Initiative 46
Missouri: Partnership in Prevention 53
Oregon: Tribal Best Practices Panel 59
Oregon 66
Rhode Island 72
APPENDIX B: CASE STUDIES ON IMPROVING BEHAVIORAL HEALTH BUSINESS PRACTICES 78
Arizona 78
Kentucky 81
Maryland 84
Oklahoma 87
Washington 91
APPENDIX C: CASE STUDIES OF HEALTH AND BEHAVIORAL HEALTH INTEGRATION 97
Arizona 97

District of Columbia 101
Maryland 105
Michigan 109
Oregon 114
Rhode Island 117

APPENDIX D. ADDRESSING CHALLENGES 122

Suggestions from states to support improvement in Behavioral Health Business Practices: . 122
Suggestions from states support improvement in Health-Behavioral Health Integration: 123
Suggestions from states to support improvement in the implementation of EBPs: 124

APPENDIX E: SEMI-STRUCTURED STATE INTERVIEW MODULES 126

Implementation of Evidence-Based Practices: 2014 State Profiles of Mental Health and Substance Use Agencies 126
Improving Behavioral Health Business Practices: 2014 State Profiles of Mental Health and Substance Use Agencies 129
Behavioral Health and Health Care Integration: 2014 State Profiles of Mental Health and Substance Use Agencies 132

APPENDIX F: CONTRIBUTORS 136

Executive Summary

State behavioral health agencies (SBHAs) are the nation's safety net in ensuring the delivery of evidence-based, high-quality services for individuals with mental and substance use disorders (M/SUDs). SBHAs include state mental health agencies (SMHAs) and single state agencies (SSAs) for substance abuse services. These agencies focus on the provision of M/SUD services for individuals who lack insurance or for those whose insurance will not pay for needed services. Annually, SBHAs expend over $45 billion providing services and supports to over 10 million individuals.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency within the U.S. Department of Health and Human Services (HHS) that is responsible for working with SBHAs. SAMHSA ensures that quality services are available to individuals who need them and helps SBHAs adapt to the changing health care environment. SAMHSA awards two types of Block Grants, the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grants (MHBG) (See http://www.samhsa.gov/grants/block-grants). States and Territories must apply for block grant funding.

In the past 2 years, two landmark federal laws have greatly affected the delivery of SBHA services. The mandates of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) require issuers of commercial insurance and Medicaid managed care plans to bring existing restrictions on M/SUD services offered through their plans to a level of parity with existing restrictions on physical health care. The Affordable Care Act expands the parity protections of MHPAEA and extends insurance coverage to millions of individuals through expansions of Medicaid, the government subsidization of insurance purchased through Marketplace Exchanges, and other insurance reforms.

Strategic Policy Areas

The effects of parity and insurance reform are having marked impacts on SBHAs in many areas. Three areas in particular are the focus of policy changes in many SBHAs:

- **Expanding the availability of evidence-based practices (EBPs).** SBHAs and SAMHSA are working to apply the expanding evidence base on the services that work best for clients with defined characteristics by increasing the availability of EBPs for individuals with M/SUDs. States that had been early innovators in adopting EBPs are now experimenting with how to expand their use as more individuals gain insurance coverage through the Affordable Care Act and parity.
- **Improving Business Practices.** For many years, M/SUD specialty systems in most states relied heavily on state general revenue funds and SAMHSA block grants, and

many providers were funded by grants from state governments. With the implementation of the Affordable Care Act and federal parity, M/SUD providers and SBHAs need to ensure that systems are established to bill new insurance (Medicaid or private insurance) whenever appropriate. This allows SBHAs to use their limited state general funds and block grant funds to cover needs that are not reimbursed by insurance or to cover individuals who remain without insurance despite the provisions of the Affordable Care Act.

- **Integration of behavioral health with physical health care.** Recognizing that many individuals with M/SUDs frequently have comorbid physical health problems, many states are working to improve the coordination and linkage of the specialty M/SUD system with physical health care. States are testing a variety of financing, organizational, and policy approaches to integrate physical health care with behavioral health care.

Review of state applications for block grant funding revealed that many SBHAs are addressing at least one of these three policy areas. A few SBHAs provided details in their block grant applications that help explain their experiences. However, little has been known about the approaches being taken by SBHAs, their successes, their lessons learned, and what technical and policy assistance from SAMHSA and others they feel would be helpful.

This report summarizes a set of case study interviews with a small number of early innovator states—those that began work on these issues before some of their peers—in each of the three policy areas. Although these case studies cannot encompass the breadth of activities being undertaken by SBHAs to improve their service systems and respond to the changes in the health care environment, they can highlight a number of experiences and lessons learned by some of the early innovators.

Lessons Learned

Create active partnerships. SBHAs are actively partnering with state Medicaid, public health, and child welfare agencies, as well as with governor's offices and state legislatures, to make certain that the needs and concerns of individuals with M/SUDs are considered and addressed as states work on health reform. The early innovator states are actively working to provide solutions and be part of policy and system changes, rather than waiting to react to changes being driven from outside their sphere of services.

Address infrastructure challenges. EBPs have been a focus of SBHAs for over a decade, but the new insurance coverage of the Affordable Care Act is providing an opportunity for their expansion as existing consumers with behavioral health service needs gain better insurance coverage and new consumers enter the system with coverage. However, the need to expand access to EBPs poses a number of challenges for SBHAs including training, infrastructure, and workforce availability.

Structure payment mechanisms to ensure fidelity to EBPs. Early innovator states are working to make certain that EBPs are an integral part of insurance benefit packages and delivery mechanisms under expanded Medicaid and integrated behavioral health and physical health care systems. SBHAs are focusing on the identification and implementation of EBPs for which the state can ensure the fidelity of the service to the practice approach established in the literature. They are structuring payment mechanisms so that providers must meet fidelity to be reimbursed for the service. Early innovators are working with their local universities and provider organizations to promote training on how to provide the EBP services and conduct fidelity assessments. Recruiting and training an expanded group of clinicians to meet the need for EBP services is a challenge. States also express concern that commercial insurance policies (particularly Marketplace plans) often do not reimburse for many of the EBPs considered fundamental to the recovery of consumers with M/SUDs.

Implement health information technology and other efficient business approaches. Improving the business practices of SBHAs and their M/SUD service providers is another major focus of early innovator states. State dollars are scarce, and there are competing state government priorities for those dollars. It is a challenge for states to meet current funding needs while also increasing state and other funds for new purposes. Therefore, SBHAs must demonstrate that they are providing cost-effective services with measurable outcomes and that state funds and block grant dollars are not spent paying for services for which insurance is available. Early innovator states are focusing on improving their health information technology (HIT) to support the enrollment of consumers with M/SUDs into the new coverage options made available under the Affordable Care Act. They are also using HIT to ensure that providers are able to identify when consumers have new coverage that can be billed before using state or block grant funds to pay for care. SBHAs have found that their partnership with Medicaid is strengthened when they can support Medicaid in ensuring that M/SUD services are billed accurately and that fraud and abuse are preempted or subsequently caught and eliminated.

Integrate behavioral health and physical health care. In focusing on this integration, each of the early innovator states is working closely with their state Medicaid agency to redesign funding systems and to ensure that behavioral health is treated in the context of the entire person. To quote a representative of one state, they are "putting the head together with the body to treat the whole person." SBHAs are combining their specialty M/SUD funding with Medicaid funding and new managed care arrangements to help with this care integration. States have also conducted analyses of (1) the high levels of comorbid physical health conditions, (2) the premature mortality of consumers with M/SUDs, and (3) the very high costs to Medicaid for providing services for these individuals, such as frequent use of emergency departments. The early innovator states that have completed these analyses credited their findings for focusing the larger health system on the need to work on the integration of behavioral health with physical health care.

Establish electronic sharing of behavioral health and primary care data within the restrictive context of existing legislative limitations. Finally, SBHAs are working with providers to implement electronic health records (EHRs) that enable the sharing of meaningful clinical data with other behavioral health providers and with primary care. Many SBHAs are partnering with state and regional Health Information Exchanges (HIEs) to facilitate the integration of data for M/SUD services with data from primary care services. However, even the most advanced early innovator SBHAs are hampered by federal rules that prevent most Medicare and Medicaid providers of M/SUD services from receiving incentive payments for implementing EHRs that meet meaningful use criteria. In addition, the federal confidentiality statute and regulations designed to protect the rights of consumers using substance use disorder services (42 CFR Part 2) has been an impediment to electronic sharing of M/SUD clinical information, which would facilitate integration of behavioral health and physical health care.

Appendices A–C of this report summarize each of the state interviews and detail more specific state examples in each policy area. Appendix D contains a summary of the challenges states identified and how states believe SAMHSA and others can help. Appendix E is a copy of the semi-structured interviews used to guide each state dialog.

Introduction

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) is working to help state mental health agencies (SMHAs) and single state agencies (SSAs) for substance abuse services improve their service system capacities to provide high-quality services for individuals with behavioral health needs. In most states, the mental and substance use disorder service authorities are now combined into a single state authority, which is labeled a state behavioral health agency (SBHA) in this report.

Recent work by SAMHSA and states has revealed that many individuals with behavioral health problems have substantial co-occurring physical health conditions, and states are working to provide better integration of behavioral health services with physical health care. The integration of physical health and behavioral health care is further supported by the implementation of the Affordable Care Act, which gives many consumers new coverage options for the first time. SMHAs and SSAs are adapting their systems to meet the behavioral health service needs of these newly covered consumers by using these coverage options to pay for their behavioral health and physical health care services. Not all states are equally advanced in the process of adapting their systems to meet these new challenges. States and SAMHSA can learn from the experiences of early innovator states that have started working on these issues.

This report describes the experiences, successes, and barriers encountered by a select group of early innovator SBHAs in adapting their behavioral health service systems to address evolving changes in health care delivery and insurance. This report identifies early innovator states in three policy areas selected by SAMHSA:

- Implementation and adoption of evidence-based practices
- Improving business practices of mental health and substance use disorder service providers
- Integration of behavioral health services with physical health care

SAMHSA's *Leading Change 2.0* report[1] highlights these three areas as important issues that are challenging for state governments. The Fiscal Year 2014-2015 SAMHSA block grant application requested that states describe their current activities and challenges in these areas, among others. Review of these state applications demonstrated that many states remain

[1] Substance Abuse and Mental Health Services Administration. *Leading change 2.0: Advancing the behavioral health of the nation 2015-2018*. Retrieved from http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2

uncertain about how to proceed, but some states stood out as being early innovators of addressing these policy areas.

States were selected as early innovators on the basis of information they provided on the block grant applications. A series of case studies are presented; they were developed from semi-structured interviews with state representatives. Supporting documents supplied by the selected states also provided insight. For example, Oregon submitted information detailing how the state reviewed and identified many behavioral health services to determine whether they qualify as evidence-based practices (EBPs).

Appendices A–C summarize each of the state interviews and detail more specific state examples in each policy area. (The summaries in the appendices were shared with each state for review/confirmation of accuracy prior to completion of this publication). Appendix D contains a summary of the challenges states identified and describes how SAMHSA and others can help. Appendix E is a copy of the semi-structured interviews used to guide each state dialog.

Purpose of This Report

With the implementation of the Affordable Care Act, states need to enhance their systems to address the new coverage options available to mental health consumers to meet their service needs. Although some early innovator states have been actively changing their systems, to date there has been no compilation of their experiences and lessons learned to guide SAMHSA and other states. This will be the first report to examine these issues across multiple states and to highlight areas where states need guidance and technical assistance.

The goals of this report are to assist states and SAMHSA in program development and to serve as a technical assistance aid in these policy areas. States can use the report to (1) identify other states implementing a program, service, or initiative that can be used as a model; (2) identify barriers experienced by other states and determine how these barriers can be addressed; and (3) learn from peer states that have implemented innovative policies and procedures.

SAMHSA can use the report to understand the experiences of early innovator SMHAs and SSAs in improving their systems to meet three of the agency's strategic goals. SAMHSA can also use the information as it works with states in implementing their mental and substance use disorder block grants and in the provision of technical assistance. Policy issues identified by early innovator states may be addressed by SAMHSA through its work with federal partners at the Centers for Medicare & Medicaid Services (CMS) and other Department of Health and Human Services (HHS) agencies.

Methodology

Selection of States

In the FY 2014-2015 Mental Health Block Grant (MHBG) and Substance Abuse Treatment and Prevention Block Grant (SABG) applications, SAMHSA asked states to supply narrative descriptions of their activities to implement evidence-based practices, to integrate health care with mental and/or substance use disorder services, and to improve or change their business practices. The process of selecting states for participation in this study had four parts.

For the first step in the selection process, a research team including members from Truven Health Analytics Center for Financing Reform and Innovation (which operates under SAMHSA oversight), the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and NASMHPD reviewed the block grant applications from all 50 states and the District of Columbia. The research team examined the extent of a state's responses to sections of the application that were related to the topics in this report (evidence-based practices, insurance enrollment and business practices, and behavioral health and physical health integration), using the SAMHSA online Web Block Grant Application System (WebBGAS) system. The research team selected the states that provided extensive responses to the relevant questions for additional review.

The second step in the process was to reread the relevant application sections from the states that provided extensive responses to determine whether the content of the state's information was relevant to the topics in this report. The third step was to summarize the states' responses.

The fourth step involved review by research team members of the proposed states and consideration of whether the selected states should be revised. This step was considered important because states known to the contributing associations as early innovators may not have highlighted all of their accomplishments in their block grant application. Additionally, states sometimes described plans for accomplishing certain innovations or objectives rather than stating what actually has been accomplished and to what extent. The final selection of early innovators focused on states with a track record of early success in a particular policy area.

A total of 10 selected states and the District of Columbia agreed to participate in the interviews. Five states and the District provided information about EBPs; Missouri and Oregon each provided two case studies of EBPs for substance use disorder services because one of the two cases highlighted a unique approach or a unique situation. Five states agreed to interviews on their business practices, and five states plus the District of Columbia agreed to interviews on integration of behavioral health and physical health. Table 1 shows the states that agreed to participate by policy area.

Table 1. Participants in the Investigation by Topic Area

State	Evidence-Based Practices	Business Practices	Behavioral Health and Physical Health Integration
Arizona		X	X
Washington, DC	X		X
Kentucky		X	
Maryland	X	X	X
Massachusetts	X		
Michigan			X
Missouri	X		
Oklahoma		X	
Oregon	X		X
Rhode Island	X		X
Washington		X	

Interview Modules

The research team developed an interview module for each policy area. SAMHSA staff reviewed the modules and offered additional comments and suggestions. The modules provided a semi-structured format for the interviews with each state on the selected policy topic. The Semi-Structured Interview Modules are provided in Appendix E.

Each interview module contained a brief statement describing the purpose of the study, the semi-structured format, and a request for additional documentation that could be included as part of the case study. The interview module also included the following general statement describing the policy area and subtopics to be discussed:

- **Implementing Evidence Based Practices**. The EBP case studies focus on (1) how EBPs supported by SMHAs and SSAs are being identified, supported, and delivered; and (2) how EBPs are changing under the Affordable Care Act and parity.
- **Improving Business Practices**. The case studies on improving business practices focus on how SMHAs and SSAs are promoting and supporting changes to provider business practices as the provision of health care services evolves. The changing business practices relate to information technology, health information systems, quality, and billing practices.
- **Health–Behavioral Health Integration**. These case studies focus on SMHA and SSA activities around health–behavioral health integration, integrated service coverage, delivery system, payment, information sharing, care coordination, and quality measurement initiatives. This report discusses areas where the states have been successful in integrating care, factors that contributed to the success, and barriers and recommendations to assist states in addressing those barriers.

Interviews With States

State mental health and substance use disorder authorities who were targeted for each policy area received a copy of the interview module prior to setting up the interviews. We then asked the states to identify staff to participate in the interviews on the basis of the information requested. We explained that the interviews would take 1 to 2 hours and states would be asked to provide additional documentation and examples of projects discussed, if such documents were available. We asked each state that agreed to participate to identify a lead or physical health care contact for each policy area identified.

NRI and NASADAD made the initial contact with states and arranged the interviews. The Truven Health team conducted interviews with states during April and May 2014. During each interview, the interviewers asked additional (new) questions related to the topic and follow-up questions. Thus the interviewers facilitated a dialog with the state staff.

After each call with the Truven Health team, we prepared notes summarizing the discussions and sent them back to states for their review and comment. Each state had an opportunity to review a draft of the case study of its activities before completion of the final report.

Summary of Findings

State Activities to Implement Evidence-Based Practices

The focus of the EBP policy area in this report is not on particular EBPs; rather, we focus on how SMHAs and SSAs are selecting EBPs to implement, how they are supporting the implementation and financing of the EBPs through their behavioral health service system, how the financing of EBPs are changing with health reforms, what the barriers to implementation have been, and the lessons learned from the early innovator states in adopting the EBPs. The case studies related to EPBs are contained in Appendix A.

1. State Activities

The research team conducted semi-structured interviews and document reviews of five states (Maryland, Massachusetts, Missouri, Oregon, and Rhode Island) and the District of Columbia. These targets were identified as early innovators of EBP services because they are implementing a variety of EBP services and funding them through a mixture of Medicaid, state general funds, and SAMHSA block grant funds.

The early innovator states all reported a long-term focus on the provision of EBP services as an important step in ensuring that their limited resources are used to provide services that are supported by research. In some early innovator states, the need to focus on EBPs was endorsed by the state government. For example, Oregon's state legislature passed a statute in 2004 mandating that a percentage of SMHA funds be devoted to the provision of mental health services. In other states, such as Maryland, strong links between the state and its universities, the National Institute of Mental Health (NIMH) (part of the National Institutes of Health), and SAMHSA have supported the development, implementation, and evaluation of EBP services using various funding sources. In contrast, Massachusetts initially implemented their EBP for opioid overdose prevention entirely with state funds.

Each state stressed the importance of selecting EBPs that have a strong evidence base and fidelity tools to assist the state in ensuring that services provided are consistent with the evidence-based practice model. All of the interviewed SMHAs used SAMHSA-developed mental health EBP toolkits for adults and Technical Improvement Protocols (TIPs) for substance use disorders to guide their implementation of EBPs. In contrast, some states implemented EBPs for substance use disorders that had no tools standardized by SAMHSA to guide their development. Examples include Oregon's tribal best practices, Missouri's substance abuse prevention for college students, and the Massachusetts opioid overdose prevention program. These states worked with existing research and other documentation to guide their efforts.

Maryland and Oregon credited participation in the development and testing of SAMHSA's EBP Toolkits as being critical to the successful implementation of EBPs and to informing the state

about the importance of fidelity to EBP models. Maryland used the Assertive Community Treatment (ACT), Family Psychoeducation, and Supported Employment toolkits, and Oregon used the Supported Employment toolkit. Maryland started ACT, family psychoeducation, and Supported Employment as part of the toolkit development process. This reinforced the importance of implementing the full EBP model and helped encourage collaboration between the state and academic institutions supporting EBPs that is continuing in Maryland today.

The SMHAs in Maryland, Oregon, Rhode Island, and Washington, DC, implemented the following original SAMHSA toolkit-supported mental health EBP services:

- Supported Employment was implemented in all early innovator states.
- ACT was implemented in all early innovator states.[2]
- Family psychoeducation was implemented in two of the states.
- Illness self-management and recovery support were implemented in two of the states.

Oregon has a list of several hundred state-identified EBPs, along with specified criteria for determining whether a service qualifies as an EBP.[3] Other interviewed states did not have formal criteria for determining which practices and services qualify as evidence-based. Instead, they relied on guidance from SAMHSA through its toolkits and National Registry of Evidence-Based Programs and Practices (NREPP) and on collaborations with academic centers within the state and information from NASADAD, NASMHPD, state staff, and other sources.

The state of Oregon recognized that standard best practices criteria have not been applied to traditional Native American practices. Therefore, they collaborated with tribal authorities to devise criteria to assess and select culturally appropriate practices; these were deemed "tribal best practices" that could be funded by the state.

Interviewed SBHAs said they primarily support the implementation of EBPs that are program-focused or team-focused rather than individual clinician-focused practices. Only Oregon cited individual clinician-focused services, such as cognitive behavioral therapy for schizophrenia and other psychotic disorders or dialectical behavioral therapy. The rationale offered by states for focusing on program- or team-based approaches was that the collection of information about training and fidelity at the individual practitioner level was beyond the capacity of their information and billing systems.

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[2] During the interview, Rhode Island discussed that with the implementation of behavioral health homes in 2012, the state shifted its focus from providing ACT to behavioral health home services. The number of consumers receiving ACT services decreased from 1,258 in 2012 to 0 in 2013, while the number of individuals receiving behavioral health home services increased to over 3,800 in 2014.

[3] State of Oregon, Addictions and Mental Health Services. (n.d.). *AMH approved evidence-based practices*. Website. http://www.oregon.gov/oha/amh/Pages/ebp-practices.aspx

Early innovator states reported that when they identify an EBP they want to support, implementation is often best initiated through a collaborative set of discussions between the SBHA and providers. SBHAs also reported that it is very helpful to include representatives from the state Medicaid agency and managed care organizations (MCOs) in early planning discussions, to help ensure that financing and service delivery systems are properly aligned and funded to support the EBP as it is implemented.

States also said they found it helpful to include consumers and family members in the discussion of new EBPs. These individuals provide useful information about their service needs, and they help support the culture and system changes necessary for implementation. Consumers and family members also help provide external support and demand for the EBP services.

1.1 Financing EBP Services

All of the states interviewed require providers to meet EBP fidelity standards in order to bill for a service at the rate established for an EBP. For example, Maryland has an enhanced rate for SBHA-designated EBP services that is conditional on fidelity. States tend to require the use of an outside organization to provide training and fidelity measurement rather than have providers certify themselves as meeting fidelity. The District of Columbia, Maryland, and Oregon use either a university-affiliated EBP center or a center of excellence (in Maryland, the state assumes the function of fidelity assessment and evaluation). The 2012 State Mental Health Agency Profiles found that 13 states (including these 3 states) were funding research/training institutes to provide on-going training to providers related to EBPs and 31 states were collaborating with universities to provide ongoing training to providers about EBPs.

All of the EBP early innovator states also stressed the significant roles of the SAMHSA block grants and state general funds in implementing the delivery of EBP services. There are certain opportunity costs at the organizational level associated with the shift to an EBP. To develop the competencies, technical expertise, and infrastructure to provide a new EBP, provider staff may need to devote time to participating in training and technical assistance. The state may need to hire new staff or establish new treatment teams for certain team-based EBPs, such as ACT and Multi-Systemic Therapy (MST). All of these activities are likely to result in diminished capacity while preparing to offer the EBP. Block grant and state general funds are useful in defraying the opportunity costs pertaining to EBP service initiation and ramp-up. Once a provider is fully trained in an EBP and has the operational capacity to deliver the service, Medicaid pays for the delivery of the EBP services for consumers who are eligible.

> The Substance Abuse Prevention and Treatment Block Grant program has been essential because it has allowed states to implement and deliver EBPs that are not reimbursed by Medicaid.

Opioid overdose prevention, prevention services on college campuses, and tribal substance use disorder services are not covered by Medicaid because they are not delivered through

the standard medical care delivery systems. States have used block grant funds and their own general appropriations funding to pay for these services.

Some states use block grant and state funds to reimburse for EBP services used by consumers who are not eligible for Medicaid. For example, Maryland uses a single payer system for providers to bill for mental and substance use disorder services, regardless of Medicaid eligibility. When a claim for services is received, the state's administrative service organization (ASO) checks Medicaid eligibility and charges the care to Medicaid if the individual is eligible. If the consumer is not eligible, state funds or block grant funds are used. The goal in Maryland is to get EBP services to consumers who need them while making sure that providers are compensated.

The District of Columbia stresses the importance of establishing rates that are consistent with the cost of providing an EBP service. If rates are inadequate to pay providers for the full cost of an EBP, providers will lack incentives to supply the full service. When the District of Columbia examined the costs of ACT and adjusted its reimbursement rates upward, it was able to greatly expand the number of consumers receiving it.

Even for consumers who are eligible for Medicaid, SBHAs have found it difficult to adequately fund some EBPs relying only on Medicaid funding. Maryland, for example, funds its nationally recognized Supported Employment service through agreements apportioning funding responsibilities between the SBHA, the state Medicaid agency, and the state vocational rehabilitation agency. Through these agreements, Maryland has been able to provide Supported Employment services for many more consumers than if it had to rely on only one funding stream.

Supported Housing is another EBP that Medicaid alone does not adequately fund. Medicaid will pay for some support services, but it will not pay for room and board costs. Rhode Island addresses this by using a combination of funding from the federal Department of Housing and Urban Development (HUD) and state funds to support room and board costs under their Housing First (Supported Housing) program of state grants to providers.

Evidence-based early intervention programs are operating in several states. Maryland has been offering Recovery After an Initial Schizophrenia Episode (RAISE) services for a number of years as part of an NIMH-sponsored research project. Oregon has a state-developed early intervention program for psychoses called Early Assessment Support Alliance, which is designed to help young adults experiencing their first episodes of psychosis. Both states are expanding these early intervention programs for psychoses, but they have found that some of the outreach and educational aspects of the programs are not billable to Medicaid and must be funded by block grants or state funds.

Health care centers of excellence are facilities that specialize in a program or service. Their goal is to improve quality of care. The funded programs in these states are designed to support EBPs by training providers

1.2 Training for EBP Services

Four SMHAs interviewed (District of Columbia, Maryland, Oregon, and Rhode Island) identified the need for providers to have adequate training to deliver EBPs with fidelity to the models. States have developed a variety of training strategies. Three of the early innovator states (District of Columbia, Maryland, Oregon) have academic centers, often called "centers of excellence." Rhode Island works with several of the universities in their state to provide EBP trainings. In most states, the SBHA provides funding for the EBP centers; however, Oregon has several EBP centers of excellence that are established and paid for by behavioral health provider organizations. The District of Columbia shares training centers with its neighboring states and has used training from Maryland's EBP Center.

In addition to funding centers of excellence to support training of providers, the interviewed SBHAs are also using these centers to support fidelity implementation. In Maryland and Oregon, the state supports training and fidelity measurement without charge to the providers as an incentive for compliance.

1.3 Effects of the Affordable Care Act on EBP Services

Several states noted that Medicaid expansion has given them greater capability to provide EBPs and more flexibility to finance these services.

Four of the EBP early innovator states (District of Columbia, Maryland, Oregon, and Rhode Island) have elected to expand Medicaid eligibility as authorized under the Affordable Care Act, and they report that this expansion of the covered population is leading to expanded capacity to provide EBP services for their consumers. The District of Columbia and Rhode Island were among the first states to expand Medicaid; both states have been able to shift a number of their existing mental health consumers from state and block grant funding to the expanded Medicaid rolls. Maryland and Oregon are both expanding Medicaid and are expecting some existing SMHA consumers to gain coverage through the Medicaid expansion.

None of the three states with specific programs for treatment of substance use disorders have been able to build on the Affordable Care Act to expand the EBPs examined in this report. Missouri has not elected to expand Medicaid. In Massachusetts, opioid overdose prevention could not be covered by Medicaid because the kits were not approved by the U.S. Food and Drug Administration (FDA). Tribal best practices in Oregon are delivered through community organizations rather than through medical providers.

Several States are using the expansion of coverage from the Affordable Care Act to transform their overall behavioral health financing.

Two of the interviewed states (Maryland and Oregon) were asked to assess the amount of state funds for providing services for existing clients that could be freed by consumers shifting to an expanded Medicaid benefit. Oregon worked with

their governor to estimate potential savings in state funds with this expansion, but they successfully made the case to repurpose the savings to expand a variety of EBP services in their system (i.e., early psychosis, supported employment, and the statewide expansion of ACT services).

As discussed in the health and behavioral health integration section, Oregon, Maryland, and Rhode Island are all using the expansion of coverage from the Affordable Care Act to change their overall financing system. Maryland has established a new ASO system that will pay for all behavioral health services using braided Medicaid, state, and block grant funds. Oregon has instituted a new system of coordinated care organizations that are responsible for paying for all health care services, including behavioral health. Both states are working with their managed care companies to ensure that EBPs are widely available and billable. Providers must meet fidelity to the EBP model to bill for service.

All early innovator states expressed concern that issuers of qualified health plans operating within the new Health Insurance Marketplaces may not be willing to pay for EBP services. The HHS Assistant Secretary for Planning and Evaluation (ASPE) estimated in 2013 that up to 62 million individuals will qualify for new or expanded mental and substance use disorder (M/SUD) coverage as a result of the Affordable Care Act and Mental Health Parity and Addiction Equity Act.[4] However, none of the SBHAs interviewed had reliable estimates of the number of current M/SUD consumers who have enrolled in the new insurance option through the Marketplaces. All of the states estimated that most of their consumers who gain new coverage through the Affordable Care Act will qualify for coverage under the Medicaid expansion rather than under Marketplace insurance, which has a higher income threshold.

Four of the interviewed SMHAs (District of Columbia, Maryland, Oregon, and Rhode Island) indicated that commercial insurance plans in their states have not traditionally paid for most of the expensive EBP services that the SBHAs are supporting, and this gap in coverage is not changing with the Affordable Care Act Marketplace Exchange insurance plans. EBPs that rely on treatment team approaches, such as ACT and MST, are rarely covered. Additionally, EBPs that support consumers in their recovery process, such as Supported Employment and Supported Housing, often are not recognized as "medical" model services that private insurance will reimburse. The Rhode Island SBHA is working with CMS and the state Medicaid agency to find funds to help support the provision of EBP services for consumers who qualify for Marketplace plans that will not pay for their EBP services.

[4] Beronio, K., Po, R., Skopec, L., & Glied, S. (2013). *Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans* (Issue brief). Retrieved from the Office of the Assistant Secretary for Planning and Evaluation website: http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

The §2703 Health Homes provisions of the Affordable Care Act also affects the delivery of EBPs by SBHAs. The ACA requires that states consult with SAMHSA as part of health home implementation. Four of the early innovator SMHAs (District of Columbia, Maryland, Oregon, and Rhode Island) are implementing behavioral health homes in their systems as either a new EBP or an emerging practice that is expected to become an EBP.

Although Maryland, the District of Columbia, and Oregon are all supporting health homes that interact with their existing ACT, Supported Employment, and other EBP services, Rhode Island has taken a different approach. In Rhode Island, all ACT services have been transitioned into a new health home service. Many of the essential service elements of ACT have been added as requirements for the Rhode Island health home model, but other services will be provided and billed separately to Medicaid. Rhode Island has seen the shift to the behavioral health home model lead to an increased emphasis on nursing and physician services and less focus on the case management aspects of ACT.

Measurable outcomes help ensure that providers and policymakers will support EBPs.

States reported that using their EBP centers of excellence and outcome measures to reinforce the importance of achieving fidelity have been important steps in changing provider culture. Tying reimbursement to achieving and maintaining fidelity has also signaled its importance to providers.

1.4 Assessing Outcomes of EBP Services

All of the interviewed early innovator states have found that having outcomes they can share with providers, state government leadership, and advocates has been very helpful in supporting the expansion of EBPs. The District of Columbia measures outcomes for several EBPs by examining client assessments at intake and following discharge. They measure recidivism, arrests, reductions in hospitalization, and functioning scales. Positive results from EBPs have been very useful to advocates working with the city council on funding for behavioral health services.

Massachusetts has put significant effort into learning about the impact of their opioid overdose prevention efforts. The results have been disseminated widely and published in a peer-reviewed journal.[5] This has been highly influential in garnering increased support in the state and across the nation for making these prevention services available.

[5] Walley, A.Y., Xuan, Z., Hackman, H.H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, … Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *British Medical Journal*, *346*, 1–12.

Oregon is in the process of transforming its reimbursement system from paying for services to paying for outcomes. The state has identified a set of metrics for its coordinated care organizations (CCOs),[6] and they are working on a set of benchmarks for service providers.

Staff Turnover is a Major Issue for EBP implementation.

States have found that they need to offer EBP training at regular intervals and use modern media (i.e., video and web-based training) to ensure EBP implementation.

2. Barriers Experienced

All of the early innovator states reported that they have encountered barriers to the implementation of EBP services. These barriers include:

Culture Change

Convincing providers of the importance of achieving, maintaining, and being dedicated to the fidelity of the EBP model can require a culture shift among some providers. There has been a persistent belief by some providers that delivering quality services that are "similar" to the EBP should be sufficient. Some providers have felt that meeting full fidelity for services such as ACT is difficult and that they can use an "ACT light" partial implementation of the model to obtain the same results. Missouri found that many providers had strong philosophical orientations toward "drug free" care and were initially resistant to making medications for treatment of addiction available. It has taken extensive technical assistance and training as well as direct actions (e.g., requirements in contracts) to establish universal access to these medications.

Staff Turnover

Staff turnover was a barrier to EBP implementation for all states. Behavioral health systems all report high levels of staff turnover, but it is especially problematic for small providers. The departure of one or two EBP-trained staff members may make it difficult to ensure that providers offer EBP services in a way that includes important program components (i.e., fidelity).

Bifurcated Funding Streams

States indicated that the necessity of funding EBPs by 'braiding' or combining funding from different sources is a barrier that makes providing EBPs complicated and difficult. Each funding source may have unique accounting and spending requirements that must be carefully tracked. In some systems, reimbursement rates for the same service may vary, depending on the funding source. Maryland has had great success in expanding Supported Employment services by partnering across three different state agencies to maximize each agency's ability to fund portions of the service. However, this level of coordination required a significant investment of time and resources at the SBHA level and thoughtful structuring of the design and service.

[6] State of Oregon. (2014). *2014 CCO incentive measure benchmarks*. Retrieved from http://www.oregon.gov/oha/CCOData/2014%20Benchmarks.pdf

Policies, protocols, and reimbursement rates had to be aligned across systems to the extent possible, to ensure that providers had seamless and unfettered access to multiple funding streams. When separate and mutually exclusive service components were defined at the system level and each was linked to a discrete funding source, providers could more easily understand the relationships among the funding streams and appropriately bill each service component to the proper funding source. The identification and cultivation of system-level champions who have devoted continual attention to cross-agency relationship building have been instrumental in sustaining and refining the braided funding model over time.

3. Lessons Learned

States described the following lessons learned:

- Early innovator states found that establishing "learning collaboratives" of providers was helpful in moving EBPs forward. In the District of Columbia, the learning collaboratives often meet monthly and help providers share experiences and solve problems.
- Conducting an EBP readiness assessment of providers was helpful to SBHAs in understanding the level of assistance needed by providers in the implementation of EBPs.
- States emphasized the importance of SBHAs working with sister state agencies—especially Medicaid, but also public health, housing, and child welfare agencies—to plan and support the implementation of EBPs.

Oregon found that no one approach worked in successfully implementing EBPs. Flexibility was essential in working with consumers and providers on their requirements.

When Rhode Island implemented EBPs, they needed considerable time to work on communications with providers, payers, and consumers. They found that hiring a full-time SBHA employee to coordinate the implementation of a new EBP was critical to moving it forward.

The District of Columbia identified four key principles for supporting EBPs:

1. The SBHA needs rules and regulations that support EBPs with fidelity.
2. Rates need to be consistent with the cost of providing EBP care.
3. Sufficient training must be made available to support the EBP.
4. Accountability and quality-improvement measures are needed to ensure that the EBP is implemented and maintained with fidelity to the model.

4. Addressing Challenges

States identified several areas where federal leadership would assist them in their implementation of EBPs. These challenges are described in more detail in Appendix D.

- The SAMHSA EBP toolkits and fidelity measures are being widely used by SBHAs to implement and monitor the provision of EBP services. Additional toolkits on new and emerging EBPs would be very valuable to states.
- States cited the SAMHSA NREPP as helpful in identifying EBPs. However, some suggested that the NREPP portfolio included too many programs, and the programs varied in their levels of empirical support. They requested that SAMHSA help states identify which programs are most appropriate and then help provide training in those services.
- The SAMHSA block grants were consistently used by states to finance the training and implementation of EBPs. The states then shifted to using Medicaid funding to pay for the EBP services on an ongoing basis. States expressed hope that SAMHSA would retain the flexibility inherent under the block grants to continue to support EBP services.
- States suggested that SAMHSA and others could support training of staff and providers on EBPs.
- States also suggested that SAMHSA and others could provide an element of the EBP toolkits that contained epidemiological estimates of how many consumers are likely to need a specific EBP service and the targeted consumer demographics.

State Activities to Improve Behavioral Health Business Practices

The case studies related to improving behavioral health business practices (Appendix B) focused on how SMHAs and SSAs are promoting and supporting changes to provider business practices as the provision of health care services evolves, especially with implementation of the Affordable Care Act. Changing business practices include system reorganization, adoption of information technology, determining quality assurance, and adapting billing practices.

1. State Activities

The Truven Health team interviewed five states on this topic: Arizona, Kentucky, Maryland, Oklahoma, and Washington. The focus for Washington is on their creation of an integrated analytic database that links data from health claims files with outcomes data from a wide variety of outcomes related to health, criminal justice, employment, and social welfare.

> AZ, KY, MD, OK and WA are adjusting many aspects of their business practices to respond to the changing insurance and health information technology landscape.

1.1 Expending Medicaid Eligibility

Four of the five states interviewed for this section expanded Medicaid eligibility as authorized under the Affordable Care Act; only Oklahoma was not expanding Medicaid at the time of this study. Medicaid expansion is expected to bring in new revenue for the providers but also increase the number of patients needing behavioral health services. States are also changing their billing practices to be able to tap reimbursement from the payers associated with the new private plan coverage options. The focus is on easing the burden on state general funds of providing services that would otherwise be funded through Medicaid or commercial insurance.

Kentucky has provided funds to their regional boards to encourage patient enrollment in either Medicaid or commercial insurance. Kentucky has enrolled more than 10 percent of its population for coverage, mostly under Medicaid. Some of the projected savings to the state general fund from expanding Medicaid coverage has been offset by Kentucky SBHA budget reductions. Because the SBHA's responsibility for paying for services has been greatly diminished, its role in Kentucky is in transition. It is now paying regional boards to enroll consumers in insurance. It is also working more closely with Medicaid as an advisor on mental health issues.

Arizona is requiring community-based mental health service providers to enroll uninsured individuals when they visit emergency departments (EDs). Maryland has found that most of the people who used the Maryland Health Insurance Marketplace qualified for Medicaid rather than commercial insurance. Maryland's ASO, which pays for claims, is also responsible for determining Medicaid eligibility. This process ensures that Medicaid pays only for the services

for which it is responsible and block grant funds are used to pay only for those services not covered by Medicaid.

Maryland officials reviewed the state health care system to assess integration of mental health, substance use disorder, and physical health care. Mental and substance use disorder authorities had developed their service and funding systems along different lines, with the former carved out and the latter carved in. The newly implemented ASO will be responsible for giving providers information about the Medicaid eligibility status of consumers seeking service and for notifying providers when an uninsured applicant may be eligible for Medicaid and should be referred to the appropriate eligibility authority. This strategy has proven effective in the administration of mental health services, ensuring that the SBHA does not pay for services that are the responsibility of Medicaid. The new ASO will collect data on all mental and substance use disorder services.

1.2 Adjusting Billing Practices and Expanding Health Information Infrastructure

Arizona was the first state to implement a statewide behavioral Health Information Exchange (HIE), but providers also use their own electronic health records (EHRs). The providers in the state's urban areas have more sophisticated EHRs than those in the rural and remote areas. The state has established standards that allow the EHRs to connect with each other and, when possible, share clinical records. To encourage the adoption and continued operation of EHRs, especially those that meet the meaningful use standards, Arizona is allowing the managed care entities to build the costs of EHRs into their contracts at the rate of 4 percent for implementation and 8 percent for operating costs. Arizona will use the Medicaid billing system for managed care entities, which allows the SMHA to collect and track data on the consumers served.

Maryland was one of the first states to adopt EHRs, although they were for physical health care rather than behavioral health. Most of their large behavioral health providers now have EHRs, which report to the state's mental health outcomes system. Only the small providers, individual practitioners, and many of the substance use disorder treatment providers do not yet have EHRs. To address this, Maryland has built health information technology costs into their ASO contract, including the costs of data reporting.

Each of Oklahoma's community mental health centers (CMHCs) has an EHR, which the state helped the providers purchase. Oklahoma also has one of the longest functioning HIEs in the country, and all CMHCs contract with it. Some CMHCs need to upgrade their systems, but Oklahoma's Grand Lake CMHC was the first behavioral health facility in the country to meet federal meaningful use standards.

Washington created a massive linked analytic database across Medicaid, state substance use disorder and mental health services, criminal justice, and social welfare agencies. The database allows the state to analyze the outcomes and financial payoffs from providing substance use

disorder and mental health services. This initiative was started many years prior to the national efforts to establish HIEs, and it demonstrated the feasibility of doing cross-system data linkage.

1.3 Improving and Strengthening Relationships With State Medicaid Agencies

The Arizona SBHA has a strong relationship with its state Medicaid agency, and this relationship facilitates coordination and integration of behavioral health with physical health services. Arizona's SBHA credits this strong relationship to constant communication between the leadership and staff of the two agencies. The Kentucky SBHA's relationship with Medicaid has become more integrated as the two agencies work together on regulations and State Plan Amendments. In Kentucky, the SBHA acts as an advisor to Medicaid, because Medicaid funds do not pass through the SBHA. In Oklahoma, a strong relationship between the SBHA and the state Medicaid agency has developed around sharing data. Maryland has been working collaboratively with their state Medicaid agency for many years. They use the ASO system to pay for services and help meet the data needs of the SBHA and Medicaid. The Washington analytic system is used for evaluation purposes and to demonstrate how reimbursement of substance use disorder and mental health services (e.g., by Medicaid) yields improved outcomes across many service systems of the state.

2. Barriers Experienced

Arizona described 42 CFR Part 2,[7] the substance abuse rule limiting the sharing of patient information for patients being treated for substance use disorders, as an antiquated regulation that hinders the development of more robust health information networks that would allow for greater coordination of care across mental health, substance use disorder, and physical health care.

Other states interviewed also cited 42 CFR Part 2 as a major barrier to sharing EHR data with physical health care providers and among behavioral health systems. In Maryland, 42 CFR Part 2 is cited as a barrier for substance use disorder treatment providers because in order to comply they cannot adopt the state's EHR system that allows for extensive data sharing. Maryland officials feel that these restrictions impede their ability to provide good-quality, holistic care because providers cannot share data that may be vital for treatment planning. In Oklahoma, 42 CFR Part 2 limits the ability to link behavioral health records. Oklahoma HIEs will only share treatment records if all treatment records are available to be shared. This is in part because there is no consent registry, which makes it impossible to determine with whom individuals have consented to share information. In Washington, 42 CFR Part 2 was not considered a problem because the system is used for research and the ultimate data set is de-identified (a process in which data that can be used to identify specific individuals is removed).

Arizona officials have encountered difficulty in fully understanding the extent to which its population is now covered by commercial insurance, as enrollment has been slow. The SBHA

[7] Code of Federal Regulations. *Title 42: Public Health. Part 2, Confidentiality of alcohol and drug abuse patient records.* Retrieved from http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

feels that this creates a potential barrier to quickly determining when services are not covered by insurance. It also limits the ability to capitalize on enrollment opportunities, such as when uninsured individuals seek treatment in EDs.

Electronic health records and the electronic sharing of EHR information are important to improving business practices. However, the high capital costs of purchasing and implementing EHR systems can be a major impediment to their implementation by small community behavioral health providers.

3. Lessons Learned

States shared the following lessons:

- It is important to have a strong relationship between the SBHAs and the state Medicaid agency.
- Ensure that the skill sets of staff match the changing needs of the agency.
- Create clear service definitions and standards.
- Engage consultants early in the process to assist states in adjusting to new business processes.
- Being among the last states to implement can be advantageous if you learn from the mistakes and successes of others.
- The appropriate use of health information technology (HIT) can be the backbone of successful system transformation.
- It takes much more time and work than states anticipate up front to do things right.
- To make transformation work, establish a working model early.
- Technology is easy, but it is difficult to create cultural change in the use of information and to work across systems.
- A strong HIT capacity can facilitate more rapid and more effective innovation by arming legislative champions with better data, outcomes, and summaries.
- The churn of individuals between Medicaid and commercial insurance creates service delivery problems.

State Activities to Integrate Behavioral Health With Physical Health Services

Health and behavioral health integration efforts in early innovator states have aimed to provide holistic care for consumers, integrate systems at the state level, realize cost savings, and engage behavioral health stakeholders in overall health care. The case studies are contained in Appendix C. The section below describes background information on the development of integration efforts, how innovator states have supported integration, how early innovators are funding integration initiatives and services, what the barriers to integration have been, and the lessons learned from the early innovator states.

1. State Activities

We interviewed the District of Columbia and five states (Arizona, Maryland, Michigan, Oregon, and Rhode Island) about their initiatives to integrate behavioral health and physical health care. Each of these early innovators is implementing integration through a variety of different models that are funded through a mixture of Medicaid, state general funds, grants, and SAMHSA block grants.

1.1 Types of Integration

In Maryland, 20 percent of health homes are co-locating physical and behavioral health care. Arizona has completely integrated homes with co-located behavioral and physical health services. Michigan is piloting an integration program titled *Healthy Michigan Plan*, which has a close linkage between physical health, behavioral health, and recovery models for patients. Early innovator states noted that the co-location model permits a strong focus on holistic health and coordinated care.

> Early innovator states have been integrating behavioral health and physical health services to varying degrees by co-locating providers and facilities and focusing on establishing a "one-stop shop" for all health services.

Early innovator states have also been combining and realigning staffing models for health homes and community-based services. Themes across early innovator states include rethinking the implementation of ACT teams and their utilization within the context of new coordinated care models. Maryland is investing heavily in health homes, with 60 behavioral health homes approved under the Chronic Health Home Option. In Rhode Island, there are currently 3,800 consumers enrolled in health homes; 1,500 to 2,000 of these consumers are Medicaid recipients.

Early innovator states have made it a priority to create coverage and accessible systems and to have targeted services for special populations, particularly adults with serious mental illness (SMI). In Arizona, for example, the state has developed intergovernmental agreements to allow tribal populations to access services through any system providing behavioral health services, including tribal services, Medicaid fee-for-service, or MCOs.

States are establishing learning communities to help providers share experiences and support integration efforts. Both Michigan and the District of Columbia emphasized their use of these communities, which are collaborative efforts between the SBHA, local community providers, and the National Council for Behavioral Health. The learning communities provide an avenue for organizing conversations, planning, training, and sharing resources within the states.

Coverage options authorized under the Affordable Care Act Medicaid expansion and the insurance Marketplaces have led to an increase in the number of individuals who are covered by insurance. This increase in coverage has resulted in projected cost savings for state general funds.

1.2 Effects of the Affordable Care Act

Rhode Island was one of the first states to implement the Affordable Care Act option of expanding Medicaid to cover single adults with incomes up to 133 percent of the federal poverty level. The expansion of Medicaid significantly increased the number of M/SUD consumers in Rhode Island who were eligible for Medicaid services. In the District of Columbia, the estimated 16,000 individuals eligible for health home services primarily will be those currently covered by Medicaid fee-for-service.

SBHAs have been partnering with a number of entities, including CMS, state Medicaid agencies, the National Council for Behavioral Health (NCBH), various information technology vendors, MCOs, universities, and small nonprofit organizations. NCBH, which represents addiction and mental health treatment providers, is one of few organizations that have emerged as notable partners across early innovator states. (See http://www.thenationalcouncil.org/about/). It has spearheaded the sharing of health integration best practices across two early innovator states (Michigan and Rhode Island).

1.3 Financing

No innovator state has funded all of its integration initiatives through one funding stream; all have needed flexible funding to implement integration efforts.

Federal grants have played a significant role in funding integration efforts in many of the early innovator states. Oregon received a $45 million grant from CMS for its Transformation Center, which is aimed at coordinating information and bringing best practices, technical assistance, and resources back to CCOs within the state.

Early innovator states have found that combining funding from several sources to implement system changes and finance integrated services has been important.

A combined collection of private foundations provided $1.5 million to fund a pilot integration program in Maryland. In the District of Columbia, State Plan Amendments helped ensure Medicaid funding for integration efforts. In Arizona, the SBHA helped drive state funding for a $1 billion state contract

to provide integrated Medicaid managed behavioral health care within the state.

1.4 Organization of Integration: Role of Managed Care

Across early innovators, MCOs or ASOs are being used for service approvals, paying providers, coordinating care, reporting data and outcomes, and providing training to providers. In many states, the MCO or ASO is responsible for checking consumer eligibility for Medicaid or other insurance and then billing those systems first, before using state funds or block grant funds to pay for services.

> Although the relationship with MCOs manifests differently from state to state, each has used MCOs as a centralized mechanism for integrated health and behavioral health.

In Arizona, MCOs receive an 8 percent administrative margin and a 4 percent profit margin in the contracted Medicaid capitation. These funds allow MCOs to subcontract to other providers to implement EHRs and exchange health information through the state's HIE.

1.5 Outcomes Measured: Health Information Technology and Health Information Exchange

Outcome measures varied, but some measures have emerged across early innovators to detail the penetration of the system and the level to which data can be shared across systems. SBHAs reported measuring ED utilization, police contacts, prison contacts, improved consumer service satisfaction surveys, peer-run services, supported employment services, rates of utilization and access to care, and rehospitalization, as well as the traditional Health Effectiveness Data and Information Set (HEDIS) measures.

Early innovator states have identified metrics around coordinated care and outcomes. In Oregon, the measures MCOs are required to collect can be accessed on their website.[8]

Maryland has developed and is using a care management tool that provides a dashboard of outcome measures. This tool allows the state to perform population health management with 30 to 40 sites across the state and with the 14 largest providers. Michigan outlines its integration efforts and measurements on their Department of Community Health website.[9]

HIT systems are seen as critical to integration and coordination of health and behavioral health information across early innovator states. State authorities are increasingly building—or assisting with the funding of building—centralized hubs that the SBHA ultimately leverages to coordinate care among providers. Early innovator states have identified HIT as an internal management and administrative lever to allow state mental health authorities to track spending and identify the interconnectedness of services across health and behavioral health. HIT systems

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[8] State of Oregon, Oregon Health Authority. (n.d.). *Technical specifications and guidance documents for CCO incentive measures*. Website. http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

[9] Michigan Department of Community Health. (n.d.). *Integrating mental health, substance use and physical health care*. Website. http://www.michigan.gov/mdch/0,4612,7-132-2941_58005-251689--,00.html

are also used as a method for providers to share information and report on services, consumer demographics, and outcomes.

Although HIEs are used by states with good EHR implementation, HIT systems and data warehouses are commonly used to manage the integration and align information in states with less sophisticated data systems and to create a central hub for provider and agency use.

The District of Columbia, for example, has invested in a system developed by an external vendor. This system allows the District SBHA to share information about diagnoses and medications, provide direct messaging to clinicians and primary care physicians, and distribute information from a client's record to the behavioral health and physical health care systems. Oregon's system captures detailed information on the services that consumers receive, and it will eventually allow Oregon to compare non-Medicaid reimbursement data with Medicaid data. This will provide invaluable management, tracking, and administrative information and ensure accurate billing, timely consumer data, and coordination of care.

Rhode Island uses its HIE to connect client data from different systems and services. Information is shared in real time between MCOs, the mental health client information system, and Rhode Island's substance use disorder data system. Data integration within the system relies heavily on participation by the MCOs that hold the relevant information.

Michigan has a robust data warehouse that includes claims data for Medicaid and comparable or parallel encounter data for non-Medicaid, publically funded services, including federal block grant funding, state and local funding for treatment of substance use disorders, and services related to mental health and developmental disabilities. Michigan has developed two key tools that use the data from their data warehouse to further population-based health and integration: (1) Care Connect 360, which is used to inform care; and (2) Data Extracts, which are used to analyze population-level data across Medicaid managed care physical health care and Medicaid specialty behavioral health care.

2. Barriers Experienced

The following list summarizes the primary barriers identified by the states.

- **Culture Change.** Early innovators found that cultural barriers emerged as a consistent concern for behavioral health organizations. Across all early innovator states there was a cultural resistance to broadening the focus of behavioral health organizations to address both physical and behavioral health.

- **Staff Training.** Across all early innovators, identifying a qualified workforce to assume coordinated care responsibilities continues to be a challenge because of the scope of integration efforts, the complexity of the work, and difficulty finding staff. The environment in HIT and integration is changing rapidly from clinical, organizational, and

technological standpoints. Recruitment of staff with qualified skills remains problematic. Early innovator states have found that the time and cost of the numerous requirements outlined in MCO contracts is increasing, and training providers will be an increasingly significant and challenging task.

- **Flexible Funding.** Across early innovator states, funding for integration has been unstable and has come from various sources. Identifying more stable federal funds and additional guidance in using block grant funds would assist in overcoming this barrier.

- **42 CFR Part 2.** As noted previously, the information privacy law limiting the sharing of patient information on substance use treatment is challenging for early innovators, because it restricts their ability to share substance use treatment data with physical health care providers and HIEs. Michigan and Arizona both cited 42 CFR Part 2 as a barrier to sharing consumer data among coordinating entities. These early innovators are researching solutions on how to handle exchange and consent restrictions.

3. Lessons Learned

The states identified a number of lessons that could help other states in their efforts.

- **Medicaid Support.** Support for health integration initiatives from state Medicaid agencies was consistently listed as a key to successful integration across the early innovator states. Medicaid's influence proved to be vital to implementing integration. Their staff provided support in writing and obtaining approval for Medicaid State Plan Amendments and Medicaid waivers, setting rates, contracting with MCOs and ASOs, supporting HIT, enrollment in Medicaid and the Marketplaces, and other issues.

- **State Leadership.** States felt that it was vital to identify a common cause, issue, report, or topic with a focus on behavioral health around which they could rally state leadership. States also found that state leadership support from the governor's office or the state legislature on prioritizing systems integration, coordinated care, and a holistic approach to care was very helpful in advancing complex behavioral health and physical health care systems.

- **Long-Term Planning.** Early innovators all advised a long-term planning effort to comprehend the complexities of integration. States cautioned that projections of the time required to achieve the desired objectives were inevitably too low, and eventual implementation of system changes can easily take from 1.5 to 3 years. All activities required time and extensive stakeholder involvement.

- **Electronic Health Records and Information Technology Infrastructure.** For behavioral health homes and other behavioral health and physical health care integration efforts, having an adequate EHR system and the ability to electronically share clinical information is essential for care coordination and workflow processes.

Conclusions

This report summarizes the results of case studies of early innovator SBHAs in three policy areas: implementation of EBPs, improvement of business practices, and integration of behavioral health and physical health. At first glance, these may seem like three distinct and separate policy arenas. However, the activities and experiences described in these case studies show that the three areas are interconnected.

SBHAs are working to link the "body with the head" to integrate behavioral health care with physical health care. This integration effort has been driven by the recognition that (1) individuals with M/SUDs are likely to have serious co-occurring health concerns and (2) the evidence of premature mortality among M/SUD consumers suggests that treatment needs related to these co-occurring health issues have not been adequately met. In addition, analyses of the total system costs to M/SUD systems and to Medicaid and other payers of physical health care show that individuals with M/SUD are some of the most expensive consumers served by Medicaid.

To address the need for integration, SBHAs are improving their business practices to share EHR and other electronic clinical information between behavioral health and physical health care systems. SBHAs are also expanding their provision of EBP services to address behavioral health and physical health care needs. All of the early innovator states interviewed for this report are in the process of implementing health homes under Medicaid.

The following improvements in business practices are ongoing:

- Changes in billing and payment procedures and systems are being used to help ensure payments for EBPs.
- Data from electronic health records and Health Information Exchanges are being used to measure outcomes from EBPs.
- EBPs are being used to help improve system outcomes and physical health care integration outcomes.
- Integration with physical health care is relying on improved business practices to ensure that appropriate payers are billed and outcomes are measured.

Appendix A: Case Studies on the Implementation of Evidence-Based Practices

District of Columbia

Types of Evidence-Based Practices (EBPs) Supported by the State Behavioral Health Agency (SBHA)

The District of Columbia Department of Behavioral Health (DBH) is currently supporting the provision of a number of EBP services for individuals with mental and substance use disorders (M/SUDs). Over the past 3 years, the DBH has reported to the SAMHSA Center for Mental Health Services (CMHS) Uniform Reporting System on the number of adults receiving three mental health EBP services and the number of children receiving two mental health EBP services (Table A-1).

Table A-1. Number of Children, Adolescents, and Adults Receiving Evidence-Based Practices in the District of Columbia, 2011–2013

	Individuals Served, N			Individuals With SMI Receiving EBP, %			Fidelity Measured
Adult EBP Services	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**	**2013**
Supported Housing	635	735	734	3.7	4.3	4.3	No
Supported Employment	--	621	700	--	3.6	4.1	Yes
Assertive Community Treatment	1,493	1,322	1,419	8.8	7.8	8.3	Yes
Adults with SMI	16,982	17,040	17,114				
Child and Adolescent EBP Services	**Individuals Served, N**			**Individuals With SED Receiving EBP, %**			**Fidelity Measured**
	2011	**2012**	**2013**	**2011**	**2012**	**2013**	**2013**
Multisystemic Therapy	118	247	96	2.6	8.1	2.7	Yes
Functional Family Therapy	58	146	218	1.3	4.8	6.1	Yes
Children with SED	4,539	3,034	3,577				

Abbreviations: EBP, evidence-based practice; SED, serious emotional disturbance; SMI, serious mental illness
Source: Substance Abuse and Mental Health Services Administration Uniform Reporting System Data

The percentage of adults with mental disorders receiving Assertive Community Treatment (ACT) in the District of Columbia is about three times higher than the U.S. average rate. The DBH presumes that this high utilization rate is a direct result of emphasizing the service by providing training, measuring performance against the ACT fidelity scale, and raising the reimbursement rate.

State Support for EBPs

Regarding the implementation and delivery of EBPs, the DBH has identified four key elements it uses to plan for and monitor each EBP it is supporting:

- Rules and regulations support EBPs with fidelity.
- Rates are consistent with the cost of providing EBP care.
- Sufficient training is available to support the EBP.
- Accountability and quality improvement need to be consistent with the EBP to assess fidelity.

The three most available EBPs for adults are ACT, Supported Employment, and Supported Housing. The DBH was able to raise the reimbursement rate for ACT, and that assisted in increasing access to this service. The DBH has been measuring the fidelity of ACT for years. They have a separate project underway to evaluate the use of the Comprehensive Psychiatric Emergency Program (CPEP) and inpatient services by ACT recipients.

For children, the DBH supports Multisystemic Therapy (MST) and Functional Family Therapy (FFT) through Medicaid and state general funds. Both of these EBPs require providers to participate in outcome measure and fidelity assessments. The DBH can track outcomes from these EBPs, and they are experiencing better outcomes than the national averages for some practices. The DBH has found that having the outcomes from the EBPs has been very helpful for advocates to use to promote EBP funding and expansion. The EBP rates for children were described as being adequate to cover costs, but getting sufficient access to EBPs remains more difficult for children than for adults.

Financing EBP Services

The DBH first focused on the development of EBPs within the SBHA-funded system using District of Columbia funds and block grant funds. Then, they were able to make the services Medicaid reimbursable to finance their broader adoption. The DBH works with the District of Columbia Department of Health Care Financing (DHCF), which is the District's Medicaid Agency, throughout the discussion, evaluation, and development process. The District of Columbia has started many EBPs with 100 percent local and block grant dollars, and they have had the successful outcome of having the services become eligible for Medicaid funding. Using this model, the District of Columbia has moved ACT from serving 350 to over 1,400 consumers over the past few years.

Implementation of EBPs for children started with having the SBHA identify EBPs. Almost all EBPs for children were started with 100 percent state funding. The DBH was able to identify reimbursement codes to determine the appropriate code to be used for Medicaid billing. The DHCF and the Child and Family Services Agency were helpful partners in this effort. The District of Columbia contracted with the Evidence-Based Association (EBA) as the broker for

identifying EBPs for youth services and for coordinating trainings. The DBH also contracts with the EBA for an annual conference on EBPs for children; the conference participants help develop ideas for implementation.

The DBH engaged their state Medicaid Agency at each juncture to ensure that EBP services would be Medicaid reimbursable. They made sure that the program was designed so that the EBP would fit within the Medicaid rubric. The state Medicaid agency and the Centers for Medicare & Medicaid Services (CMS) need to provide approval, but they do not require a state plan amendment to pay for new EBPs.

The District of Columbia has worked to establish unique billing codes for each EBP to ensure appropriate reimbursement and to assist with data collection. For some EBPs, the DBH examined existing codes and created its own rate for local (state-funded) reimbursement until the services could be established as Medicaid reimbursable. To bill for an EBP service, all providers must be certified as meeting fidelity. The DPH certifies all EBP providers, and they are the recognized authority on certification of providers who may bill Medicaid. The District of Columbia has the ability to identify and stop using providers who do not meet fidelity.

State Support for EBP Training of Providers

The DBH has found that their direct-care workforce has a high turnover rate; therefore, they built replacement training capacity for staff providing EBPs. The most utilized EBPs have quarterly staff training. For several EBPs, the DBH has been able to provide training regionally with Maryland, Pennsylvania, and Virginia. The DBH is also training employees to become master trainers so that they can provide training to others on a regular basis.

The DBH is paying for replacement training through its EBA contract. They have learned not to provide training too much in advance of EBP implementation. In the past, they provided training to a number of professionals before the EBP was fully ready to implement, and providers lost their EBP-trained employees through turnover.

To assist behavioral health providers to pay for training time, the DBH includes adequate funding to cover training costs in their service rates. When the DBH first started providing training on EBPs, they had a grant that covered staff time for training. However, the grants are no longer available, and funding for training from general revenue funds is built into service rates to add additional clinicians.

In the DBH, children's behavioral health providers have compiled local dollars to support implementation of training. Third parties perform pre- and post-implementation training on EBPs. The DBH, in partnership with the EBA, also hosts an annual conference on EBPs for children; this conference has been helpful to providers and advocates in identifying new EBPs and garnering support for the implementation of EBPs.

Effect of the Affordable Care Act Expansion of Insured Population (Expanded Medicaid and Marketplace Insurance) on EBPs

The EBPs in the District of Columbia are supported primarily by Medicaid. With Medicaid expansion, more consumers will have coverage for these services. The DBH does not expect many private insurers to pay for EBPs. The DBH has not had commercial insurance companies partner with the public system to provide EBP services. There is relatively little utilization of EPBs by commercially insured individuals, including those who have insurance through the Health Insurance Marketplace. The DBH would like to partner with private providers in the future.

As the DBH moves to create health homes that include behavioral health services, they will continue to provide ACT services along with the health home services.

Measurement of EBP Outcomes

DBH staff review outcomes for adults using ACT and other EBPs on an annual basis. For children and adolescents using EBP services such as FFT and MST, the DBH conducts measurements at intake and discharge. The DBH has found that providers are obtaining excellent outcomes for these services. For MST and FFT, the DBH surpassed national averages in completion and successful outcomes for families. Positive outcomes include reduced recidivism, reduced number of arrests (or no arrests), and reduced use of hospital services. These outcomes have been very helpful to advocates who share this information with city council. The Children's Roundtable—composed of advocates, providers, managed care organizations, and other stakeholders—receives outcome measures on a regular basis.

Starting in September 2014, the DBH will be implementing the *Child and Adolescent Functional Assessment Scale* (CAFAS) to provide additional functional outcomes for this population. The DBH will administer the scale at intake, every 90 days, and at discharge. Providers of children's EBPs that contract with the DBH will be required to completing the assessments. This new functional assessment tool will replace the existing *Child and Adolescent Level of Care Utilization System* (CA-LOCUS) that has been required of providers.

Barriers to EBP Implementation

The DBH has found that their largest barrier is navigating the multiagency and multi-insurance public system. The vast majority of individuals covered by Medicaid are enrolled in Medicaid managed care organizations (MCOs) that have responsibility for all office-based mental health services. Office-based EBPs may have different rates for public health organizations and MCOs. This is more of a problem for clinic services and less of a problem for rehabilitation-option funded services.

There was some initial resistance from providers regarding implementation of EBPs because of the level of effort and changes in existing practices required. However, now that providers are

seeing positive outcomes and support from consumers, they have become supportive partners. In the DBH, the overall number of children receiving services has been stable, but more children are now receiving EBPs.

Lessons Learned

A key component to implementing an EBP is having adequate initial funding. These funds can be used to train providers and get them started before they can begin billing Medicaid.

The DBH found that it is very difficult to implement EBPs without appropriate infrastructure. This includes a readiness assessment of providers. Additionally, the DBH found that their Learning Collaboratives are very important. Providers that conduct training meet on a monthly basis for support and information.

Maryland

Types of Evidence-Based Practices (EBPs) Supported by the State Behavioral Health Agency (SBHA)

Maryland offers a number of EBPs for individuals with mental and substance use disorders (M/SUDs). Effective July 1, 2014, the state substance use disorder agency and state mental health agency were merged into a single behavioral health agency.

Maryland pays for all EBP services using Medicaid, state general funds, and block grant funds through a contracted administrative services organization (ASO). Community mental health services are purchased from community-based outpatient mental health centers, psychiatric rehabilitation program providers, and other private nonprofit providers. Over the past 3 years, Maryland has reported the number of adults receiving four different mental health EBP services to the SAMHSA Center for Mental Health Services (CMHS) Uniform Reporting System (see Table A-2).

Table A-2. Number of Adults Receiving Evidence-Based Practices in Maryland, 2011–2013

	Adults Served, N			Adults with SMI Receiving EBP, %			Fidelity Measured
EBP Services	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**	**2013**
Supported Housing	8,160	8,659	9,084	15.3	15.2	15.1	No
Supported Employment	2,693	2,793	2,922	5.0	4.9	4.9	Yes
Assertive Community Treatment	2,411	2,712	3,159	4.5	4.8	5.3	Yes
Family Psychoeducation	62	11	16	0.1	0.0	0.0	Yes
Adults with SMI served	53,480	56,876	60,025				

Abbreviation: EBP, evidence-based practice; SMI, serious mental illness

Source: Substance Abuse and Mental Health Services Administration Uniform Reporting System Data

State Support of EBPs

Maryland has been supporting the development and implementation of EBPs through a collaborative relationship with the University of Maryland, Baltimore since the early 1990s. This Behavioral Health System Improvement Collaborative trains providers and other staff on EBPs. The EBPs that Maryland is supporting include:

- *Supported Employment*. Maryland was one of the first states to implement Supported Employment. The state was involved in the national SAMHSA EBP Implementation Project ("tool kit" development). They have expanded the number of sites offering Supported Employment from 6 to 35.

- *Assertive Community Treatment (ACT).* Prior to 2004, Maryland had mobile treatment teams in multiple jurisdictions. These teams are similar to ACT, but they do not have all the required elements. The state also had one Program of Assertive Community Treatment (PACT) that predated the statewide ACT implementation. Maryland has been implementing ACT since 2004. The state currently has 19 ACT teams that provide ACT with fidelity to the model, but statewide coverage is not yet available. Initially, ACT was covered by funding from a SAMHSA grant. ACT is now a Medicaid billable service.
- *Family Psychoeducation.* This service is available in three programs, and fidelity is being measured. Family psychoeducation is reimbursable by Medicaid, although the SBHA does provide funding to the programs for a portion of the family intervention coordinator's services.

Maryland is also developing and supporting other EBPs:

- *Recovery After an Initial Schizophrenia Episode (RAISE).* RAISE is a National Institute of Mental Health (NIMH) sponsored research project that seeks to improve outcomes related to schizophrenia at the earliest stages of the illness. This service includes helping people with schizophrenia lead productive and independent lives, thereby reducing long-term treatment costs. Maryland has been involved with RAISE since 2009 and is building on the RAISE model to develop six early intervention teams. Maryland's efforts also focus on education and outreach to hospitals, schools, and other settings and provide consultation to clinicians on assessing and treating those presenting with first-episode psychosis.
- *Mental Health First Aid*. Maryland has a partnership with Missouri related to Mental Health First Aid. This national program provides initial help to individuals in mental health crisis before they receive formal behavioral health services. It can include peer and family support. Mental Health First Aid was initially funded under a SAMHSA Mental Health Transformation Grant; it is now funded using state general revenue funds.
- *Health Homes*. Health homes are being established through a partnership with Medicaid using the Missouri health home model. These homes are limited to individuals who are in opioid replacement treatment programs and individuals in psychiatric rehabilitation programs. Since their establishment in October 2013, Maryland has 60 behavioral health home programs serving 3,780 individuals.

Financing EBP Services

Maryland has had an enhanced rate structure for EBPs since 2006. The enhanced rates apply to providers that adhere to the EBP model. When a provider has completed training and technical assistance on the model, the state will evaluate their fidelity to an SBHA-designated EBP at the request of the provider. If a program meets the EBP threshold established by the SBHA, they

may bill at the EBP rate for the service; otherwise, the service is reimbursed at the non-EBP rate (e.g., the non-EBP supported employment for mobile treatment).

Medicaid can be billed for most EBPs if the individual is eligible for Medicaid. For individuals who are not eligible, services are paid through the Mental Health Block Grant or through state general funds. To support the provision of EBPs, Maryland braids the different funding strands together and bills each strand when appropriate, with Medicaid as the preferred funding source. Maryland is dedicated to ensuring that their providers are compensated for the provision of needed services, even when consumers are not eligible for Medicaid.

State Support for EBP Training of Providers

Maryland has worked on EBPs with the University of Maryland for a number of years. The Maryland Mental Hygiene Administration (MHA) began a partnership in the early 1990s that established a Training Collaborative to support workforce development and training. In 2002, MHA expanded the traditional MHA and University of Maryland partnership with the creation of the Mental (now Behavioral) Health Systems Improvement Collaborative at the university. This collaborative currently consists of three centers: the Training Center (TC), the Evidence-Based Practice Center (EBPC), and the Systems Evaluation Center (SEC). These centers function interactively to educate, evaluate, and advise the public mental health system (PMHS). The EBPC was designed to serve as Maryland's infrastructure for dissemination of evidence-based, promising, and best practices, including an initial focus on the National Evidence-Based Practice (NEBP) project. The SEC was designed to enhance Maryland's capacity to evaluate the PMHS and provide feedback about its current functioning. Further, the SEC assists the MHA in identifying and monitoring system outcomes; this resource is seen as critical to the current and future rollout of EBPs in Maryland, because the design and monitoring of outcomes is central to efforts aimed at sustaining lessons learned and gains made. Additionally, in the NEBP Project the SEC was seen as the vehicle for the monitoring and evaluation required.

Maryland has considered providing individual clinician training for clinician-specific EBPs such as Dialectical Behavioral Treatment (DBT) and Cognitive Behavioral Therapy (CBT), but the state is not currently offering training for individual clinician-focused EBPs.

Effect of the Affordable Care Act Expansion of Insured Populations (Expended Medicaid and Marketplace Insurance) on EBPs

As a result of the implementation of the Affordable Care Act, a number of people who were previously uninsured are now covered by Medicaid. For those individuals who were previously covered under the Primary Adult Care waiver, it has been a relatively seamless process to transition the financing of those services from general fund dollars to Medicaid. For people churning between Medicaid and private insurance, there is difficulty ensuring continuity of services.

Maryland obtained a Medicaid Primary Adult Care Waiver for individuals, which covered most nonhospital-based services for indigent, childless adults who had a chronic condition. As of January 2014, 95,000 individuals who had been covered by this waiver were moved to full Medicaid coverage, meaning that they are covered for inpatient and other hospital-based care. The savings realized by this shift to full Medicaid was taken out of the Department of Health and Mental Hygiene (DHMH) budget. This shift of resources has not created any adverse service impact.

There have been difficulties providing services for people covered by Medicare because that population tends to need more services than their Medicare benefit allows. This is especially true for older adults receiving ACT services. Medicare covers only a very small portion of the cost of ACT services. For those who are not eligible for secondary Medicaid coverage, DHMH fills the coverage gap using state general funds to pay for nonclinical services on ACT teams.

Measurement of EBP Outcomes

Much of Maryland's outcome measurement data is collected as part of the Outcomes Measurement System embedded within the ASO's authorization platform. This is supplemented by data that are collected by the EBP Center on Supported Employment and ACT. The Supported Employment outcomes are based on the outcome measures developed by and collected for all states participating in the Johnson & Johnson and Dartmouth Community Mental Health Project. For data that otherwise are not collected, certain data outcome measures can be extrapolated from claims data, such as employment tenure. Fidelity is generally easier to measure than outcomes. However, Maryland believes that it is equally important to measure outcomes, and the state is ensuring that outcomes are collected with the same rigor as is fidelity. As a result, Maryland is in the process of refining the methodology of collecting ACT outcome measures to ensure the accuracy and integrity of the data collected.

Barriers to EBP Implementation

Maryland reports that their largest challenges are related to expanding EBP access and penetration. The recent recession represented another barrier. Prior to the recession, Maryland was aggressively moving ahead with EBPs, but the recession limited the expansion because it was difficult to maintain existing behavioral health funding and there was no new funding available. Coming out of the recession, Maryland feels that there will be more opportunities for expanding services and service access.

Even though Maryland is one of the most densely populated states, the state has problems expanding EBPs in certain rural areas because there is an insufficient volume of consumers to support the service infrastructure necessary to make it cost effective.

With Supported Employment, Maryland has experienced problems maintaining services with fidelity because of staff turnover. To develop workforce competency, Maryland is moving

toward the use of more online training platforms and is trying to imbed EBPs into the culture of programs, so the sustainability of the service does not rely on individual practitioners.

Lessons Learned

For Maryland, the key factors in any success they have had implementing EBPs is their relationship with the Behavioral Health System Improvement Collaborative at the University of Maryland, Baltimore; the funding flexibility they have established; and their relationship with stakeholders. The Behavioral Health System Improvement Collaborative helps to maintain the singular focus on EBPs, and the SBHA deals with a multitude of presenting issues and crises. Their relationship and collaboration with stakeholders is so pervasive that it has become normal and expected. Their stakeholders have been advocates for EBPs; they are educated and aware of DHMH's activities, including those related to EBPs.

Massachusetts: Bystander Naloxone Distribution Program Preventing Fatal Opioid Overdose

Naloxone (Narcan) is a prescription medication that reverses the effects of an opioid overdose.[10] Massachusetts has progressively developed a statewide naloxone distribution initiative, titled the *Massachusetts Opioid Overdose Education and Naloxone Distribution* (OEND) program. This initiative aims to prevent fatal opioid overdose by distributing naloxone to active users, friends and family members of users, and first responders.

Target Population, Responses to Their Needs, and Components of Innovation

Opioid-related deaths in Massachusetts increased steadily from 1990 into the 2000s. As the number of deaths increased, communities began searching for ways to combat the growing opioid problem that was caused by misuse of both heroin and prescription drugs. In 2006, the Boston Public Health Commission authorized the creation of an opioid overdose prevention program that included the distribution of intranasal naloxone kits and overdose response education.[11] Naloxone is administered via intramuscular injection or, in this case, intranasally. It binds to the opiate receptors in the brain while displacing opiate molecules, thereby reviving the person who has overdosed and restoring normal breathing.[12,13] Naloxone is not a controlled substance and has no misuse potential,[14,15] but it is available only by prescription. This policy makes it difficult for family members and other "bystanders" to obtain naloxone, because physicians are generally required to write prescriptions only for the person who will take a medication. The person who has overdosed on opioids will be unconscious and need someone else to administer the drug. Emergency departments stock and administer naloxone; however, many individuals who have overdosed do not make it to the hospital in time. Witnesses may fear calling 911 because of police involvement,[16,17,18,19] which leads to delays in emergency response

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[10] Kim, D., Irwin, K. S., & Khoshnood, K. (2009). Expanded access to naloxone: Options for critical response to the epidemic of opioid overdose mortality. *American Journal of Public Health, 99*(3), 402–407.

[11] Doe-Simkins, M., Walley, A. Y., Epstein, A., & Moyer, P. (2009). Saved by the nose: Bystander-administered intranasal naloxone hydrochloride for opioid overdose. *American Journal of Public Health, 99*(5), 788–791.

[12] Bazazi, A. R., Zaller, N. D., Fu, J. J., & Rich, J. D. (2010). Preventing opiate overdose deaths: Examining objections to take-home naloxone. *Journal of Health Care for the Poor and Underserved, 21*(4), 1108–1113.

[13] Kim et al. (2009).

[14] Bazazi et al. (2010).

[15] Kim et al. (2009).

[16] Baca, C., & Grank, K. (2007). What heroin users tell us about overdose. *Journal of Addictive Diseases, 26*(4), 63–68.

[17] Burris, S., Norland, J., & Edlin, B. R. (2001). Legal aspects of providing naloxone to heroin users in the United States. *International Journal of Drug Policy, 12*(3), 237–248.

[18] Seal, K., Downing, M., Kral, A. H., Singleton-Banks, S., Hammond, J. P., Lorvick, J., . . . Edlin, B.R. (2003). Attitudes about prescribing take-home naloxone to injection drug users for the management of heroin overdose: A survey of street-recruited injectors in the San Francisco Bay Area. *Journal of Urban Health, 80*(2), 291–301.

[19] Tracy, M., Piper, T. M., Ompad, D., Bucciarelli, A., Coffin, P. O., Vlahov, D., & Galea, S. (2005). Circumstances of witnessed drug overdose in New York City: Implications for intervention. *Drug and Alcohol Dependence, 79*(2), 181–190.

times. Putting naloxone into the hands of friends and family members removes these barriers and increases the likelihood that the individual's life can be saved.

Development and Components of Innovation

At the state level, the Bureau of Substance Abuse Services (BSAS) of the Massachusetts Department of Public Health learned about overdose deaths that were occurring all over the state. Once the Boston program was underway, representatives from the Boston Public Health Commission approached the BSAS about taking it statewide. At the same time, the BSAS was reviewing their substance use disorder data as part of the state's Strategic Prevention Framework State Incentive Grant (SPF-SIG) from SAMHSA. Using the Strategic Prevention Framework, state grantees review health data to identify their state's prevention needs, build their prevention capacity, develop a strategic plan, implement effective programs and policies, and evaluate the programs' outcomes.[20] In completing the data review, it became clear to the BSAS that opioid overdose was the most pressing substance use concern facing Massachusetts. With Boston's program already underway, SPF-SIG was able to bring the BSAS naloxone bystander program statewide as part of an effort to reduce and prevent fatal opioid overdose.

The Massachusetts opioid OEND pilot project began in 2007. To reach the most high-risk populations, the BSAS used the state's existing HIV prevention infrastructure and partnered with seven HIV outreach organizations in high-need areas to be distribution sites. These organizations already had strong ties to the active user community and could train overdose responders and distribute naloxone as part of their other outreach and engagement activities. Using a "train the trainer" model, all the chosen sites completed the BSAS's 4-hour overdose prevention training using a curriculum[21] that includes (1) general information about opioids and opioid overdose; (2) how to recognize and respond to an opioid overdose, including performing rescue breathing, administering naloxone, and calling 911; and (3) risk factors for an overdose. This training was followed by several supervised training sessions.[22] Once trainers at the distribution sites completed their BSAS training, they began training and distributing naloxone kits to individuals who came to their site to enroll in the pilot. OEND has a doctor on staff to serve as the pilot project's part-time medical director. This physician also serves as the medical director of the Boston Public Health Commission Opioid Treatment Program as well as an Assistant Professor at the Boston University School of Medicine. Using a "standing order" model, the OEND physician writes a standing order (a standard medical order) for each of the

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[20] Substance Abuse and Mental Health Services Administration. (2014). *Strategic prevention framework*. Retrieved from http://www.samhsa.gov/spf

[21] Massachusetts Department of Public Health. (n.d.). *Opioid overdose education and naloxone distribution: MDPH naloxone pilot project core competencies*. Retrieved from http://www.mass.gov/eohhs/docs/dph/substance-abuse/core-competencies-for-naloxone-pilot-participants.pdf

[22] Agency for Healthcare Research and Quality. (2014). *State health department and community agencies save lives by teaching potential bystanders to recognize and respond to opioid-related overdoses*. Retrieved from https://innovations.ahrq.gov/taxonomy-terms/opioid-overdose

pilot sites, which allows people who have completed the overdose prevention and response training to receive a naloxone kit. This method is common among naloxone distribution programs to allow staff to distribute naloxone without having a physician present to write individual prescriptions.

One of the HIV organizations involved in the pilot is the Statewide Partnership for HIV Education in Recovery Environments (SPHERE). This organization works specifically with providers to educate them about HIV and harm reduction. As a member of OEND, SPHERE trained substance use disorder treatment program staff on how to respond to opioid overdoses and how to incorporate opioid overdose prevention education into their treatment work.[23] The BSAS also has provided technical assistance on opioid overdose to providers of substance use disorder treatment, including creating and disseminating guidance on how to integrate opioid overdose prevention into treatment programs.[24] The guidance document[25] describes effective prevention strategies and refers providers to a variety of other opioid overdose tools.

As the project got under way, more sites became interested in participating. Since 2007, an additional 20 sites in communities across the Commonwealth have joined the pilot. In addition to HIV outreach organizations, which focus primarily (but not exclusively) on enrolling active users, parent support groups called *Learn to Cope*[26] also became interested in participating. Learn to Cope is a support group for parents and other family members of people with addictions. Groups meet regularly throughout the state, and interested parent volunteers from a group can enroll as distribution sites in the pilot project by completing the BSAS's overdose prevention training. Once officially enrolled in the pilot, trainers begin receiving naloxone kits from the BSAS. The BSAS also has expanded their prevention efforts to include working with physicians and pharmacists to further increase access to naloxone through prescriptions and encouraging pharmacies like Walgreens to stock and distribute naloxone kits; however, the OEND bystander pilot remains the Bureau's top priority.

OEND was controversial at the beginning. Negative attitudes about illegal drug use and toward drug users made the BSAS's initial efforts unpopular throughout the state. Those attitudes began to shift as drug users and families of individuals who had overdosed recognized the lifesaving potential of widespread naloxone distribution and became involved with and advocates for the project. Parents have been an important constituency, helping to change public perceptions.

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[23] Statewide Partnership for HIV Education in Recovery Environments (SPHERE). (2014). *The overdose prevention training initiative*. Retrieved from http://healthimperatives.org/onlineed/overdose-prevention

[24] Massachusetts Department of Public Health, Bureau of Substance Abuse Services. (2014). Website. http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/

[25] Massachusetts Department of Public Health, Bureau of Substance Abuse Services. (2014). *Practice guidance: Integrating opioid overdose prevention strategies into treatment*. Retrieved from http://www.mass.gov/eohhs/docs/dph/substance-abuse/care-principles-guidance-opioid-overdose.pdf

[26] Learn to Cope. (2014). Website. http://www.learn2cope.org/

First responders, specifically police and fire departments, also became interested in distributing naloxone. Often the first to respond to a 911 call, police officers and firefighters are not traditionally equipped or allowed to administer medications, including naloxone. In 2010, the Quincy Police Department, in the Boston area, approached the BSAS about distributing naloxone. Using the same "standing order" model, Quincy became the first Massachusetts police department to have their officers carry naloxone. Now, police and/or fire departments in six communities have been trained and distribute naloxone.

Collecting data is an important component of OEND. All of the sites submit data to the Medical Director, who reviews the reports and manages data in partnership with the Boston University School of Public Health. As participants are enrolled in the program, they complete a one-page questionnaire that asks about drug use, experience with substance use disorder treatment, and past overdose. These questions vary slightly by participant (e.g., active user, family member). Sites also collect data on participants who request a naloxone refill, asking questions that include whether the individual has reversed an overdose. These data allow the BSAS to track the growth of the program and provide information to share about its outcomes.

Collaboration: Single State Agency (SSA) for Substance Abuse Services and Stakeholders

OEND has gained supporters and stakeholders over the years. The BSAS has been its biggest champion since its inception, but the Boston Public Health Commission has been its most important collaborator. Boston was the first of Massachusetts's public health entities to implement a comprehensive response to opioid overdose. Boston's work provided a blueprint for the BSAS to use to expand the naloxone distribution pilot statewide. The OEND medical director has also been instrumental to OEND's success. The medical director volunteered to write standing orders at a time when many (if not most) physicians were unwilling to take on the perceived liability of putting naloxone in the hands of nonmedical personnel. The medical director has also published a number of peer-reviewed studies on the Massachusetts pilot, helping to grow the evidence base of bystander naloxone distribution.

First responders and parents of drug users also have become important stakeholders in the project. These groups, particularly parents, helped to broaden the public's view of drug overdose and make the case that saving lives should be a top priority. This support has helped fuel the growing acceptance of overdose prevention, with public officials in Massachusetts and elsewhere progressively lending their support. This is specifically evident from the Massachusetts Governor's declaration in March 2014 that the opioid addiction epidemic has created a public health emergency.[27] As part of the declaration, the Governor outlined a number of action steps that will be taken in response to the epidemic: permit all first responders to carry and administer

[27] Massachusetts Department of Public Health. (2014). *Governor Patrick declares public health emergency, announces actions to address opioid addiction epidemic*. Retrieved from http://www.mass.gov/governor/pressoffice/pressreleases/2014/0327-governor-declares-public-health-emergency.html

naloxone, mandate the use of prescription monitoring data by prescribers, and dedicate $20 million to increase treatment and recovery services.

Costs and Financing Sources

Total program costs for the OEND pilot total roughly $530,000 each year and include purchasing naloxone, medical expenses, and data collection and analysis. Each naloxone dose costs $21.41, and each naloxone kit contains two doses and two nasal atomizers. The BSAS purchases all of the naloxone for the program and distributes it to the participating sites. The annual cost of purchasing naloxone totals roughly $400,000 and represents the bulk of program costs. Annual medical director expenses total roughly $39,000, and data collection and analysis costs total roughly $91,000. Costs associated with staff time (BSAS and distribution programs) have not been calculated.[28]

This program is made possible through funding directly from the BSAS. They have identified the OEND program as a priority and dedicated their resources as such. This includes funding the Bureau receives from the Substance Abuse Prevention and Treatment Block Grant and state appropriations. These investments are significant relative to the Bureau's total funding and to OEND's reach and success.

Success, Challenges, and Lessons Learned

Since its first enrollment, OEND has enrolled more than 24,000 unique individuals. *Enrollee* refers to an individual who has received the overdose prevention and response training and a naloxone kit. Roughly two-thirds of enrollees are active users and one-third of enrollees are nonusers. A total of 2,867 overdose reversals have been reported by enrollees. An additional 443 overdose reversals have been reported by first responders. A study conducted by the OEND physician also showed that communities where OEND was implemented had lower adjusted overdose death rates (46 percent lower in communities where more than 100 of every 100,000 residents were trained and 27 percent lower where 1–100 of 100,000 residents were trained) than communities where OEND was not implemented.[29,30] In comparison with communities without OEND distribution sites, implementing OEND reverses individual, potentially fatal overdoses and lowers the overdose death rate. This is significant because these outcomes provide evidence

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[28] Massachusetts Department of Public Health, Bureau of Substance Abuse Services. (n.d.). *Opioid overdose education and naloxone distribution: MDPH naloxone pilot project core competencies* (Information sheet). Retrieved from http://www.mass.gov/eohhs/docs/dph/substance-abuse/core-competencies-for-naloxone-pilot-participants.pdf

[29] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., . . . Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *British Medical Journal*, *346*, 1–12.

[30] Agency for Healthcare Research and Quality Health Care Innovations Exchange. (2014). *State health department and community agencies save lives by teaching potential bystanders to recognize and respond to opioid-related overdoses*. Retrieved from http://www.innovations.ahrq.gov/content.aspx?id=3912

that OEND is meeting its objectives, and it is also significant that these data exist and are accessible to the BSAS.

Data collection is a vital component of any program, because it enables program administrators to track the program's success. Data also can be used to provide additional justification for a program's expenditures or even its existence. In the case of OEND, data have been an essential tool for the BSAS to be able to make a strong case in favor of OEND's methods and objectives and to add to the evidence base of bystander naloxone distribution. This helps sustain the BSAS's overdose prevention work and offers other communities designing their own response to growing opioid overdose deaths another evidence-based tool to consider. The BSAS's partnership with Boston University's School of Public Health to manage and analyze the data also has been tremendously helpful.

The BSAS's greatest obstacle in implementing OEND was a lack of public support for and approval of naloxone distribution. In the face of that opposition, BSAS persevered and made significant investments in what they defined as their most pressing public health issue. This perseverance and leadership from the BSAS have been keys to OEND's survival and success and ultimately to dissemination of this evidence-based practice across the state. Making the financial investments necessary to sustain OEND also has been critical. These investments signal BSAS's commitment to OEND and its objectives.

Missouri: Medication-Assisted Treatment Initiative

Access to SUD Medications in the Public Treatment System

Missouri was selected to showcase its statewide integration of Medication-Assisted Treatment (MAT). This case study shows that the Missouri Department of Mental Health's Division of Behavioral Health (DBH) was able to increase access to MAT through a number of steps. They first worked with the legislature and other partners to make funding for MAT more available through new sources. They also facilitated communication between providers, other state agencies, and the drug manufacturer to ensure that all stakeholders were involved in becoming educated about the benefits of MAT and participated in working through its implementation.

The DBH has long considered medications an important adjunct to substance use disorder treatment. They are part of providing an individualized and whole-patient approach that—combined with counseling and support services—offers patients who meet eligibility criteria an important opportunity to engage in treatment and to achieve recovery. Medications approved by the U.S. Food and Drug Administration (FDA) for alcohol dependence include naltrexone (oral and depot injection), disulfiram, and acamprosate calcium. Approved medications for opioid dependence include buprenorphine (with and without naloxone) and naltrexone (oral tablet and depot injection).

Missouri has gradually been able to expand access to the full array of FDA-approved medications. Although staff members at the Missouri DBH felt that it was important to continue to offer methadone and buprenorphine, in 2006 they decided that the demand for those medications would continue without a concerted effort on their part. The DBH felt that there was a real need to focus efforts on expanding access to other medications that treat alcohol and opioid dependence. It should be noted that Missouri currently has 12 opioid treatment programs (OTPs): 4 public or nonprofit and 8 for-profit. By the end of 2014, 15 were projected, with 3 new OTPs planned for more rural parts of the state. Of these, 8 OTPs will offer both methadone and buprenorphine to their patients. Missouri's average OTP 1-day enrollment census is 2,800. SAMHSA's buprenorphine locator currently lists 146 physicians and 13 treatment programs in Missouri.

Collaborative Partnerships

In November 2006, the DBH was awarded a Robert Wood Johnson Foundation (RWJF) Advancing Recovery Grant, which focused on treating people with severe alcoholism using acamprosate and naltrexone. The grant included funding for 23 treatment providers. The RWJF "walkthrough" process was used to identify staff resistance and organizational roadblocks to offering the medications. Motivational interviewing was emphasized as a way to increase client engagement. Provider contracts were amended to reimburse for physician time, medications, and laboratory services.

The DBH always had a good relationship with their provider association, the Missouri Coalition for Community Mental Health Centers. Providers were told that there would come a day when they would be expected to provide all FDA-approved medications in order to be certified by the state. In October 2008, the Advancing Recovery Grant ended and monthly Change Leader conference calls began with treatment program directors and other stakeholders. The purpose of these calls was to provide education on treating opioid dependence with depot naltrexone and to work through any issues with integrating its use. The single state agency (SSA) for substance abuse services developed a relationship with the drug manufacturer, and the manufacturer provided ongoing technical assistance and training to the providers on these calls and assistance on an individual basis as questions arose. Although these educational efforts were focused on injectable naltrexone, the DBH believes that educating providers about this medication was helpful in breaking down barriers and resistance to using other medications. The manufacturer also provided peer-to-peer counseling, with doctors counseling doctors and nurses counseling nurses. This was particularly effective in gaining providers' buy-in to use medications in treatment.

The Missouri Department of Corrections has also been an important partner, participating in the Change Leader calls convened by the SSA. In 2008, the DBH worked with the Department of Corrections to provide funding to support the purchase of medications for clients in the criminal justice system who were seeking treatment.

Similarly, the SSA has worked closely with the Office of State Courts Administrators (OSCA) and with individual judges. A St. Louis drug court judge who was an early adopter of MAT was concerned that offenders were relapsing or overdosing before they could come before his drug court. He worked with the DBH to pioneer the use of injectable naltrexone in the St. Louis jail. Offenders received a dose just prior to being released and then were referred to treatment in the community. This project has since been replicated in other jails through a pilot project discussed below. Drug courts include medications as a reimbursable service, and all drug courts are encouraged to use MAT. The DBH reviewed the Request for Proposal (RFP) that is distributed to drug court contracts and suggested language that that was accepted. Providers are asked to indicate whether MAT is provided; if it is not provided, they are asked how and with whom MAT services are arranged and how all services are coordinated.

Another important partner has been the Missouri Recovery Network. They have also been an advocate for MAT, with leadership championing MAT as an evidence-based practice (EBP) before the general assembly. The DBH noted that supportive leadership facilitated their progress.

SSA Process for Working With Providers

In working with Missouri providers, the idea was to begin with a simple message: make this medication available, and eventually providers would be expected to offer the full array of

approved medications. Along with the monthly Change Leader calls, the DBH also contacted providers individually. Providers were encouraged to work with their medical directors to determine appropriate screening instruments and the duration of treatment with the medication. Providers varied in the speed with which they were able to offer medications or refer to other physicians, with some moving quickly to expand their use and others adapting more slowly. The larger providers had physicians on staff, but rural providers faced difficulties finding physicians who were willing or able to participate, with some having to look in telephone directories. In what is described as a 3-year process, the providers moved from being encouraged to provide access to all medications to the requirement that, in order to be certified, they must show that they are either providing access to these medications or that there is a mechanism for referral to another physician who could provide the medications.

The medications, physician and nursing services, and lab tests are reimbursed at cost. When the provider refers an individual to a physician, the physician sends the bill to the provider who is then reimbursed by the state. The SSA is thus able to examine billing records to verify that the medications were actually provided. Note that this applies only for providers funded by the state; it does not include nationally accredited providers, for which the state creates a reciprocal certification rather than a direct certification. For the funded providers, the SSA is able to collect and analyze these billing records. Medicaid in Missouri also reimburses for all FDA-approved medications except for methadone; the cost for methadone dosing is reimbursed, but not the cost of the medication itself. Medicaid claims data are accessed and analyzed. On a quarterly basis, all providers are able to see a breakdown of data from their own clients compared with the state average. The analysis shows what percentage of those with an eligible diagnosis of alcohol or opioid addiction received the appropriate medication. Based on the quarterly results, DBH staff members follow up with providers to discuss any problems or needs for technical assistance.

Provider Perspective

Four St. Louis providers were interviewed to gain context and perspective. They were two large providers with sites throughout the state (one of which offers medically managed withdrawal services), a smaller St. Louis agency, and a provider that focuses on male offenders being referred from correctional institutions or drug courts. All described the majority of their client populations as presenting with a primary diagnosis of dependence on heroin or opioid pain relievers. Although it was mentioned that there are different models used in other agency sites in the state, three of the St. Louis providers used injectable naltrexone as the primary medication for treatment. For these particular providers, injectable naltrexone was used predominantly for opioid dependence. This drug may be used to treat alcohol dependence in other parts of the state; as noted below in statewide data, it has been the most effective medication in engaging clients with alcohol dependence. One provider mentioned that he had expected a large demand for buprenorphine, but it was more common for clients to ask for naltrexone based on word of mouth.

Two of the providers described themselves as "old school," and they were not initially receptive to the idea of using medications. However, they began to see the benefits as they learned more through the technical assistance provided and as they saw clients participating in groups and enrolling in college. The DBH noted a paradigm shift for both counselors and community support specialists.

For the two providers who treat their clients with opioid dependence primarily with injectable naltrexone, the process of initiation into treatment typically takes 21 days, depending on the client's opioid tolerance. Treatment typically begins with buprenorphine, for which clients receive an initial dose and then are gradually tapered off. Clients are then given oral naltrexone; if they can tolerate naltrexone, they are then transitioned into injectable naltrexone. One weakness in the early years was that staff and clients were not sufficiently educated about the tapering process for buprenorphine, and they saw a high dropout rate as clients were tapered off of this drug. Currently, staff members place a greater emphasis on educating the clients about the tapering process at intake, provide information about the medication, and sign a contract during the early phases of treatment. These contracts are reviewed and revisited on a regular basis. During the week when clients are transitioning off of buprenorphine, it is important to increase home visits or phone contacts to keep the clients engaged. The provider whose clients use buprenorphine as a longer-term maintenance treatment medication also mentioned contracts as being an important part of the treatment.

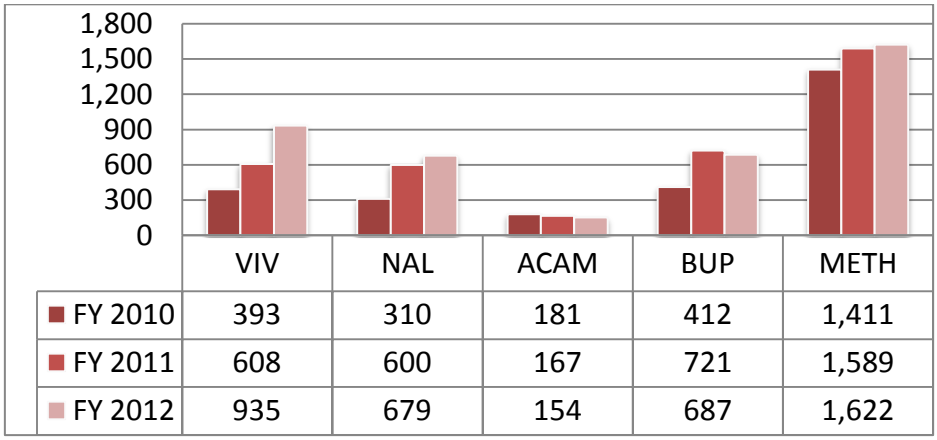
A number of the providers use an outside entity to provide the medications and lab services, and another critical piece is the communication between the agency providing the counseling services and this outside entity. One program director participates in weekly visits. Providers also emphasized the importance of counseling and follow-up recovery services and the need to stress at the outset that the medication by itself is not a cure. At a broader level, providers indicated that the commitment and leadership of the SSA was very important to the integration of MAT, as was the support and participation of all federal, state, and institutional partners.

One provider discussed a promising pilot called the Reducing Recidivism Project. Male offenders in three prisons who have completed 1 year of substance use disorder treatment are educated about MAT, given a prerelease injection of naltrexone, and provided with case management services that link them to treatment in the community. The project began 1.5 years ago and is being evaluated as part of a study by Texas Christian University. The community linkage part of the project became operational in October 2013, and 98 percent of the men being released kept their first appointment at the community-based treatment program.

Accomplishments

The data in Figure A-1 for the period from fiscal year (FY) 2010 through FY 2012 reveal that Missouri has been able to increase access to a broad range of medications, with only acamprosate showing a decline.

Figure A-1. Number of Individuals Served With Medications



	VIV	NAL	ACAM	BUP	METH
FY 2010	393	310	181	412	1,411
FY 2011	608	600	167	721	1,589
FY 2012	935	679	154	687	1,622

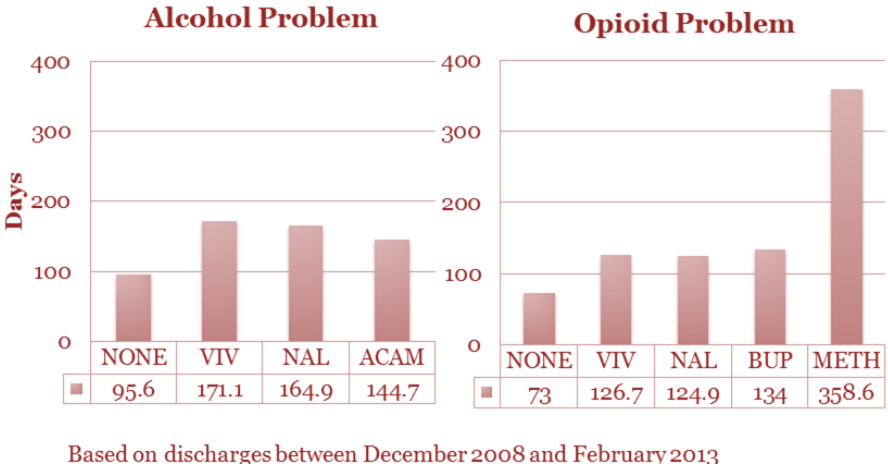
Note: Medications used in detoxification are excluded.

Abbreviations: ACAM, acamprosate; BUP, buprenorphine; METH, methadone; NAL, naltrexone, VIV, Vivitrol®

Source: Missouri Department of Mental Health, Division of Behavioral Health, Unpublished Data.

Medications seem to increase client engagement. Figure A-2 shows the average length of engagement in days. The results indicate that Vivitrol was most effective for clients with alcohol problems and methadone was most effective for those with opioid problems.

Figure A-2. Average Length of Engagement, in Days



Note: Medications used in detoxification are excluded.

Abbreviations: ACAM, acamprosate; BUP, buprenorphine; METH, methadone; NAL, naltrexone, VIV, Vivitrol

Source: Missouri Department of Mental Health, Division of Behavioral Health, Unpublished Data.

Patients using MAT were compared with those receiving no medication assistance on a variety of characteristics, including psychiatric problems, average years of use, and unemployment. Results showed that those in the MAT group were described as more "difficult to treat" at intake.

The same groups were compared on treatment outcome measures, including no drug use in the past 30 days, employment, no arrests in the past 30 days, and participation in self-help groups. The results showed that outcomes for the patients using MAT were either comparable or better than outcomes for those not using MAT.

Another unique goal of Missouri's MAT integration was to expand telehealth services. In August 2009, the DBH allowed medication services to be provided through telehealth. MAT physician services delivered through telehealth showed a steady increase:

- **2011**: 1,678
- **2012**: 2,321
- **2013**: 4,222
- **2014**: 3,482 (as of June 2014 when this report was written)

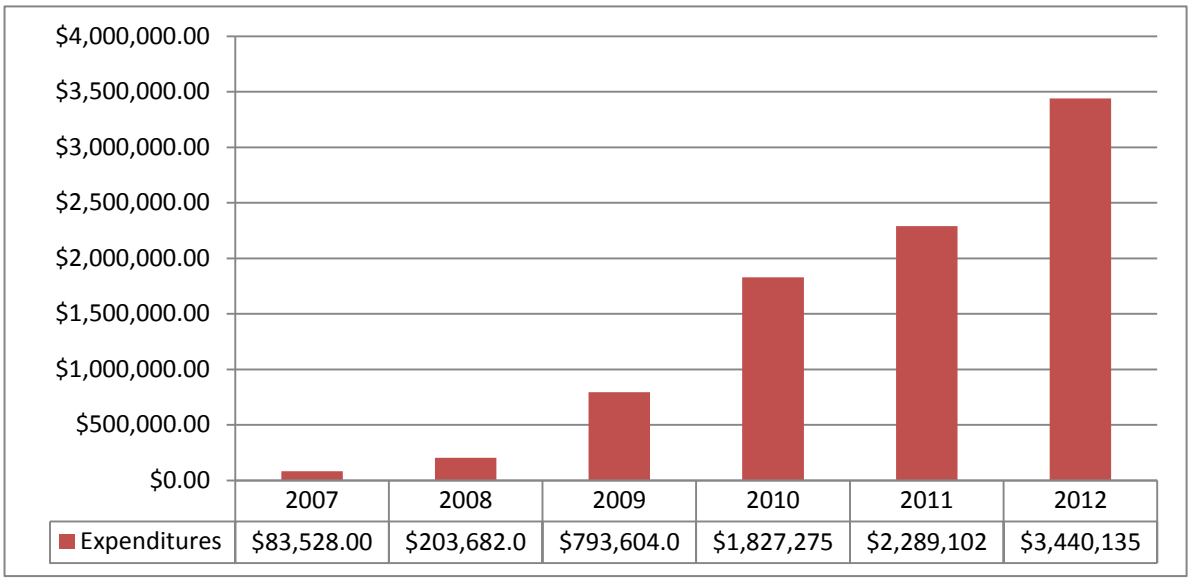
Financing

The 2006 RWJF grant helped initiate this program, but there were other factors that made it possible. In 2008, the DBH worked to introduce substance use disorder treatment medications as a dedicated line item in the budget. In May 2009, $1 million was appropriated for medications. This general revenue funding has continued to be automatically appropriated every year and adjusted for inflation, so that in 2014 the fund has reached $2.1 million. The line item includes medications, lab services, and physician and nursing services, but it does not include overhead costs. When this fund is exhausted, providers can use state contract funds.

Early in the process, the DBH partnered with the Medicaid state agency to ensure that MAT drugs are included on the Medicaid formulary, and they assisted in the development of clinical utilization approval criteria. Although the cost of the methadone is not covered for opioid dependence, the dosing of methadone is a reimbursable activity under Medicaid. There is also money in the DBH budget that is dedicated solely to the provision of MAT for non-Medicaid consumers. The DBH has also encouraged providers to take advantage of opportunities to purchase medications at reduced rates. Several years ago, the DBH partnered with a medical supply company to bring a "bulk buy" opportunity to providers for discounted injectable naltrexone, and they maintain good relationships with the drug manufacturer so that they are made aware of any programs or offers that might lead to cost savings. Through one of these collaborations, described later in this report, the drug manufacturer funded a prerelease first injection for offenders, and the DBH provided funding for subsequent injections received in community treatment agencies. In addition, the DBH encourages providers to "price shop" for the best price on medications and to explore partnerships with federally qualified health centers or rural health centers to access 340-B pricing, which allows for significantly discounted prices for medications.

DBH data reveal a rapid increase in spending on all medications and indicate that this spending covers a full range. For the period from FY 2007 to FY 2012, the Division provided unpublished data that expenditures for substance use disorder medications (excluding methadone) increased from $83,528 to $3.44 million over 5 years, which is a 74 percent annual rate of growth over this period.

Figure A.3. Annual Substance Use Disorder Treatment Medication Expenditures



Source: Missouri Department of Mental Health, Division of Behavioral Health, Unpublished Data.

Challenges and Lessons Learned

One lesson learned in Missouri was that it was important to have a champion at every site; for example, one nurse was able to make a large difference at an agency where staff had been previously reluctant. Unity within the DBH was also very effective, enabling them to speak with one voice and set expectations at the highest level.

In terms of challenges, even with Missouri's relative generosity with regard to financing for MAT as compared to other states, fiscal realities continue to be a challenge and providers must triage their services. Interviewees felt that MAT would have grown faster had overhead costs been included in the mandatory budget line item.

In terms of next steps, the goal is to continue with providing education, training, and technical assistance. These features have been and will continue to be critically important.

Missouri: Partnership in Prevention

A Consortium of Higher Education Institutions to Address Substance Use Disorders

Partners in Prevention (PIP) is a statewide consortium of colleges and universities in Missouri dedicated to creating healthy and safe campus environments. PIP provides training and technical assistance to its campus members and serves as a clearinghouse of education materials, policies, and the latest prevention research related to substance use disorder.

The original PIP coalition consisted of 13 institutions of higher education. It was formed in 1999 through a U.S. Department of Education Fund for the Improvement of Postsecondary Education (FIPSE) grant to reduce and prevent high-risk drinking among Missouri's college students. Since then, the consortium has grown to include 21 colleges and universities serving public, private, technical, and religiously affiliated campuses in Missouri.

Partners in Prevention first received Substance Abuse Prevention and Treatment Block Grant (SABG) funds from the Missouri Department of Mental Health, Division of Behavioral Health (DBH) in 2001. Block grant funds support small grants for member campuses and PIP staffing infrastructure, located at the University of Missouri. Additional funding sources have been secured in recent years to address specific student health and safety issues, as described later in this case study.

Population, Needs, and Components of the Innovation

According to the Partners in Prevention website, PIP's mission is—

> To create a campus, city and state environment that supports good decision making in regards to alcohol by the college students who attend the higher education institutions in the State of Missouri.[31]

The consortium also works to decrease substance misuse and other problematic health and safety behaviors of Missouri's college student population. According to the PIP Director, member campuses receive training and technical assistance to help them interpret data, build coalitions, develop strategic plans, evaluate interventions, implement environmental prevention strategies, and learn more about current prevention "hot topics." PIP coalition members meet monthly for training and networking and host an annual statewide prevention conference called *Meeting of the Minds*.

The PIP statewide approach is data-driven and assessment-focused. Each school collects data on its students using the Missouri College Health Behavior Survey (MCHBS). The online survey is anonymous. It has been implemented during each spring semester since 2007. It collects information to understand the impact of alcohol, drugs (illegal and prescription), mental health

[31] Partners in Prevention. (n.d.). Website. http://pip.missouri.edu/

issues, and gambling on student health and wellness. The MCHBS also provides information about attitudes, perceptions of other students' behaviors, campus and community laws, and policies. PIP staff members help participating schools implement the survey and analyze the data for individual campuses and in aggregate at the state level. PIP member colleges and universities have access to their own data. The data allow each campus to examine the students' baseline alcohol and other drug (AOD) usage patterns, track trends, and measure the effectiveness of program implementation and policy changes over time. The data also inform decisions about where to focus their prevention efforts.

Each year, PIP members are required to draft and implement a strategic plan for their campus community using their student survey data. Each campus's approach depends on the individual needs of the campus. Schools work closely with PIP staff to develop their strategic plans, decide what problems to address, and select evidence-based prevention strategies. Campuses receive funding for prevention efforts only after the plans are submitted and approved. Campuses have used the money for educational materials (e.g., posters, brochures); give-away and incentive items for students to participate in alcohol screenings and other similar events; late-night, alcohol-free events for students; additional police enforcement during large, problematic student celebrations; staff training; peer educator certification; and travel to the statewide Meeting of the Minds conference. PIP members are not permitted to use the money for staff to coordinate the campus initiatives. Having a part-time or full-time dedicated prevention professional on campus illustrates the member campus' commitment to providing adequate resources and an infrastructure necessary to reduce health and safety problems among students.

Collaboration: State, Local, and Campus Stakeholders

The PIP consortium receives funding from the Missouri Division of Behavioral Health through an SABG. The Block Grant supports PIP staffing infrastructure, the Missouri College Health Behavior Survey (MCHBS), and small grants to member campuses. In addition to the Missouri Department of Mental Health's DBH, other statewide partners include the Missouri Division of Alcohol and Drug Abuse, Youth Suicide Prevention Project, Missouri Division of Alcohol and Tobacco Control, Missouri Department of Transportation, and the Missouri Department of Public Safety.

Response to the PIP consortium has been very positive. The PIP Director stated:

> Collaboration between PIP staff and the Division of Behavioral Health is fantastic! The agency recognizes that we are the experts and they trust us to know what institutions of higher education need to address 18–24 year-old college students' alcohol and substance misuse prevention issues. The agency also provides that necessary link to K-12 alcohol and drug prevention services.

The Prevention Director with the Missouri Division of Behavioral Health has also been very pleased with the PIP collaboration. He commented:

> My staff liaison communicates often with PIP staff, attends their monthly meetings and annual conference, and informs them of other relevant grant opportunities. The PIP structure is an efficient and cost-effective way to provide statewide prevention support to many people.

To participate in PIP, the college president or other senior administrator must support campus involvement in the coalition and be committed to tackling student alcohol and drug misuse issues. Campus leaders must also ensure that adequate staff members are in place to carry out the necessary prevention work. Lead campus staff members who serve as the liaisons with PIP staff are typically employed in the university counseling center, health or wellness center, residence life, or dean of student's office.

PIP members form campus committees and build relationships with key stakeholders to work on preventing or reducing problematic student health and safety behaviors. Likely stakeholders and collaborators include student life administrators, health and wellness staff, residence life staff, counseling staff, campus judicial officials, fraternity and sorority staff, activities and program staff, athletic department staff, local law enforcers, bar owners, landlords, and students, among others. The key partners in any campus and local community coalition vary, depending on the problems being addressed and the prevention strategies being implemented. PIP campus members are also encouraged to work with any local substance use disorder prevention coalitions and other likely collaborators to help with their prevention efforts. In addition to the prevention work being done on any individual campus, there are ample opportunities to share resources and lessons learned with each another. According to one campus staff coordinator, the trainings and support from PIP and her counterparts at the other member schools are invaluable to the success of individual and collective campuses.

Costs and Financing Sources

The Partners in Prevention consortium receives $341,000 annually from the Missouri Division of Behavioral Health to support PIP staffing and infrastructure; implement the Missouri College Health Behavior Survey (MOCHBS) on member campuses each spring; travel to monthly meetings in Columbia, Missouri (4 hours on the first Friday of the month, 8–9 times per year); provide training at the monthly meetings; and support the annual Meeting of the Minds conference. The funding also supports a few "drive-in" workshops or webinars throughout the year. Currently, 21 Missouri colleges and universities are PIP members. The original 13 campuses receive grants of $10,000 each year, and the other 8 receive about $2,500 to $3,000 annually. As mentioned previously, these funds are intended to provide materials and programs, not to hire staff.

In recent years, PIP acquired additional federal and state grants to address other student health and safety issues. These include efforts to address driving under the influence (DUI); tobacco cessation and prevention programs; treatment of prescription drug misuse; mental health

promotion; supporting the mental health needs of student veterans and students who are lesbian, gay, bisexual, or transgendered (LGBT); treatment of problem gambling; and suicide prevention. PIP also provides training and resources to member campuses related to reducing student high-risk drinking and underage drinking. Finally, PIP provides technical assistance and support for these other efforts.

Success, Challenges, and Lessons Learned

PIP and individual campuses have experienced many successes because of the training support and collaborative nature of the coalition. According to PIP's website, the following outcomes have been achieved:

- An increase in the number of campus and community coalitions throughout the state
- An increase in the skill level of students and professionals who participate in training opportunities
- Baseline data on students at all participating Missouri colleges and universities
- A decrease in availability of alcohol to college students
- An increase in the number of alternative, alcohol-free programming in the participating campus communities
- A decrease in student drinking rates, including binge drinking, average number of drinks per week, and number of times students drink per week
- A decrease in the negative consequences of binge drinking, including violence
- An increase in the accuracy of students' perception of their peer's AOD use

Most notably, the overall binge-drinking rate[32] of college students in the state has decreased from 34 percent in 2007 to 26 percent in 2013. Since 2007, there has been a significant reduction in the number of underage students engaging in binge drinking at campuses served by the coalition.

Member PIP campuses also report success. One campus coordinator stated that because of being involved in PIP, (1) student high-risk drinking was reduced and (2) the campus senior administration dedicated staff to coordinate the prevention activities. Another campus coordinator reported that they also saw a reduction in student high-risk drinking. Other successes include more collaboration among different university departments and an increase in the number of peer educators.

The PIP coalition has received recognition for its work. In 2009, they received the Community Anti-Drug Coalitions of America (CADCA) *Got Outcomes! Coalition of Excellence Award* in the Coalition in Focus category, which recognizes coalitions that demonstrate contributions to community-wide declines for one substance-related issue. In 2008, the National Prevention

[32] *Binge drinking rate* is the percentage of students having five or more drinks in a 2-hour period.

Network recognized the work of Partners in Prevention with the *2008 National Exemplary Award for Innovative in Substance Abuse Prevention Programs, Practices, and Policies.*

One of the challenges has been the loss of national prevention resources for institutions of higher education. The PIP director stated:

> Just a few years ago, we could rely on training, technical assistance, and prevention resources from the Higher Education Center. Since its funding was eliminated, PIP is now *the* support for not only member campuses, but others in Missouri, if asked.

Along that same line, a member campus stated that as they have experienced success, there is an expectation to do more without additional staff or funding. The member felt that it has been challenging to accomplish everything with limited resources.

Another challenge is sustainability. If the SABG funding was eliminated or reduced, the PIP statewide coalition might dissolve since the block grant supports the infrastructure to staff and coordinate trainings and facilitate communication among the campuses. According to the member campuses, it would be difficult to continue at same level if the SABG funding was eliminated or reduced. One campus coordinator believes that the infrastructure and support PIP provides is more important than the individual campus grants. In other words, the support, training, and information received from PIP are much more valuable than the $10,000 grant her campus receives.

During the course of any initiative, many lessons are learned that help inform best practices and any necessary changes in course direction. The Partners in Prevention coalition is no different, in that the PIP staff and individual campus coordinators have learned important lessons. Some of these lessons include:

- Each campus has its own story, and each has the best knowledge of its students and the specific problems they face.
- Campuses are at different stages of readiness to address a particular problem, depending on the issue.
- It is necessary to work with campuses “where they’re at” and provide leadership based on that premise. Some campuses are farther along in the process than others.
- Campuses do not need to do accomplish everything on their own; PIP staff will always help.
- Being a PIP member is like being in a classroom—member campuses are continuously learning from each other.

- The expectations from PIP and the funding provided to the campus help focus and motivate campus leaders, campus coordinators, and coalition members.
- It is important to get buy-in from a senior campus administrator, because most decisions and work designation originate at this level. Administrative support provides the opportunity to do the work and the time to do it.

Conclusions

The PIP coalition appears to be an innovative mechanism for using Substance Abuse Prevention and Treatment Block Grant dollars to provide training, technical assistance, and resources to many recipients. Providing funds to support an infrastructure and skilled staff that are responsible for filtering that expertise to similar member organizations illustrates the effectiveness of the hub and spoke model. The PIP staff and member campuses have experienced many successes that may not have occurred without support to (1) foster the transfer of skills and knowledge related to substance use disorder prevention and reduction and (2) develop the relationships among campuses and state staff members that facilitate sharing of data, policies, strategies, and lessons learned. Institutions of higher education, residents of their surrounding communities, and students continue to face many problems related to high-risk drinking, substance use disorder, and other unhealthy behaviors. Prior to 2012, colleges and universities could rely on a national resource to provide training and resources related to effective prevention strategies. Because of funding cuts, that resource is no longer available. The Missouri example demonstrates how SABG funds can be used effectively to support prevention efforts targeting a high-risk population and to provide the necessary skills for those responsible for creating healthy and safe campus environments.

Oregon: Tribal Best Practices Panel

Recognizing Substance Use Disorder Treatment Practices in Native American Communities

The State of Oregon collaborated with tribal members and experts to form the Oregon Tribal Best Practices Panel. Their purpose was to develop an innovative approach to identification of culturally responsive and effective services, interventions, and practices to address the substance use disorder (SUD) problems of Native American communities and citizens. Unfortunately, there are very few interventions for SUDs directed toward Native Americans that meet standard medical research standards for recognition as evidence-based practices (EBPs). The health sector in the United States has increasingly attempted to direct funds toward EBPs to demonstrate accountability and outcome effectiveness. Oregon and tribal representatives realized that a different model was needed to identify approaches to treatment of SUDs that build on Native American practices, traditions, and values.

Target Population and Response to Their Needs

Oregon's tribal governments antedate the existence of the federal and state governments. Native American residents are citizens of their tribes. The tribes are separate sovereign entities that have the authority to "protect the health, safety and welfare of their members and to govern their lands," and since 1924, their members are also citizens of the United States.[33] In the 1950s, Oregon tribes were terminated by the U.S. federal government. In the 1970s, some of them were gradually reestablished, but the affected tribes are still working to restore their traditional government and culture.[34]

According to the 2012 U.S. Census, Oregon's tribal population includes an estimated 70,196 people who identify themselves as being *American Indian or Alaskan Native*.[35] Oregon's tribal people live in all 36 counties of the state and make up about 1.8 percent of the total state population.[36] There are currently nine federally recognized tribes in Oregon: Burns Paiute Tribe; Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians; Confederated Tribes of the Grand Ronde Community of Oregon; Confederated Tribes of Siletz Indians; Confederated Tribes of the Umatilla Indian Reservation; Confederated Tribes of Warm Springs; Coquille Indian Tribe; Cow Creek Band of Umpqua Tribe of Indians; and Klamath Tribes. Most of Oregon's tribes are confederations of three or more tribes and bands. Each tribe's area of interest extends beyond its tribal governmental center or reservation location. The federal

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[33] Oregon Secretary of State, Oregon Blue Book. (2014). *Introduction to Oregon's Indian tribes*. Retrieved from http://bluebook.state.or.us/national/tribal/tribalintro.htm

[34] Oregon Secretary of State, Oregon Blue Book (2014).

[35] United States Census Bureau. (2014). *State & county quickfacts: Oregon*. Retrieved from http://quickfacts.census.gov/qfd/states/41000.html

[36] Oregon Secretary of State, Oregon Blue Book (2014).

government recognizes that many tribal members do not live on tribal lands, so it allows tribes to provide certain governmental programs in specified service areas.[37] During restoration, tribes were given land by the federal government to share with each other, so each tribe does not have its own reservation. The Burns Paiute Tribe, Umatilla Indian Reservation, and Confederated Tribes of Warm Springs are the only three reservations in the state.

In 2003, Oregon's Senate Bill 267 stated that five state agencies (Commission on Children and Families, Department of Corrections, Department of Human Services Office of Mental Health and Addictions Services, Oregon Criminal Justice Commission, and Oregon Youth Authority) would be required to show that a portion of their program funding would be spent on EBPs: 25 percent in 2005, 50 percent in 2007, and 75 percent in 2009.[38] Tribal populations were concerned about this new EBPs requirement, as it was not in line with their cultural values. There is generally a sense of skepticism among Native Americans about federal policies that have been put into place for the benefit of the dominant society. Because of the historical trauma endured by Native Americans, there is some resentment and distrust of words or concepts such as *science, research*, and *studies* that have been harmful to tribes in the past.[39] There is also wariness about any external government-imposed mandates that have not been previously discussed with tribal authorities.

Because one of the key components of the establishment of EBPs is randomized controlled studies, research practices of the dominant culture are inherently discordant with Native American cultural values. The tribal cultural values of generosity and respect do not allow providing an intervention to some members of the community while denying it to others.[40] Another incongruity between the two cultures is that in mainstream scientific research, data are collected based on what is observed; in Native American culture, it is "disharmony in the unseen world that is reflected and observable in the seen world," so it is the unseen world that requires intervention.[41] According to Native American tradition, solely intervening in the visible aspects of life would be considered insufficient to create change. Another issue with EBPs in tribal populations is that most of the communities are too small to support the rigorous expectations of

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[37] Oregon Secretary of State, Oregon Blue Book. (2014). *Introduction to Oregon's Indian tribes*. Retrieved from http://bluebook.state.or.us/national/tribal/tribalintro.htm

[38] Cruz, C. M., & Spence, J. (2005). *Oregon tribal evidence based and cultural best practices*. Oregon Department of Human Services, Addictions and Mental Health Division. Retrieved from http://library.state.or.us/repository/2007/200710220927381/index.pdf

[39] Cruz & Spence (2005).

[40] Cruz, C. M. (2005). *Tribal best practices: There are many pathways*. Oregon Department of Human Services, Addictions and Mental Health Division. Retrieved from http://www.oregon.gov/oha/amh/ebp/native-american/presentation.pdf

[41] Cruz (2005).

random sampling, and most tribes are too closely knit to prevent those in control groups from communicating with those in the experimental groups.[42]

Another reason that tribal communities were averse to requiring EBPs is that they believe that the dominant culture's linear approach to funding requirements were being imposed upon them. Dr. Janet Bennett, an expert on intercultural communication, describes a linear approach as one that is "conducted in a straight line, developing causal connections among subpoints towards an end point."[43] In contrast, the Native American culture utilizes a circular approach, in which "discussion is conducted in a circular movement, developing context around the main point, which is often left unstated."[44] Tribal representatives voiced these concerns about the dominant culture's research practices to the state, and the two entities began collaborating to reach a solution.

Collaboration: State Agency and Tribal Populations

Native American communities within the State noticed a paucity of EBPs on the National Registry of Evidence Based Programs and Practices (NREPP) that were tailored to their population. They asked for their traditional tribal practices to be recognized as adequately fulfilling the newly imposed EBP requirement. After hearing feedback from Native American providers and stakeholders, the Oregon Health Authority Addictions and Mental Health (AMH) Division took the following position:

> Because scientific evidence for imposing practices on Native American providers is lacking, AMH concludes that we need a different framework for working with Native American stakeholders. Native American stakeholders must take the primary role in defining what works for Native American clients. To obtain a framework that makes sense to the Native American community, AMH will consult with Native American researchers and providers, requesting that these researchers and providers design and develop a framework for evaluating and disseminating effective practices that makes sense in the context of Native American culture and values.[45]

As a result of the discussions within AMH, the Tribal Best Practices (TBP) Panel was established to determine which tribal practices could be deemed best practices and would meet requirements for funding. The TBP Panel was created with the help of tribal governments and

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[42] Cruz (2005).

[43] Cruz, C. M., & Spence, J. (2005). *Oregon tribal evidence based and cultural best practices*. Oregon Department of Human Services, Addictions and Mental Health Division. Retrieved from http://library.state.or.us/repository/2007/200710220927381/index.pdf

[44] Cruz & Spence (2005).

[45] Oregon Health Authority, Addictions and Mental Health Division (2007). *Position paper on Native American treatment programs and evidence-based practices*. Retrieved from http://www.oregon.gov/oha/amh/ebp/Position%20Paper%20on%20Native%20American%20Treatment%20Programs%20and%20Evidence-Based%20Practices.pdf

AMH, and it began to review practices about 6 years ago. The panel consists of 10–12 people who are a combination of substance use disorder prevention and mental health promotion workers from the state and tribal communities. The panel operates autonomously, serving as a liaison between the tribal authorities and the state government. It serves as an advisory group, debating the inclusion of potential TBPs, and it acts as an approval body for tribal practices, convening on an as-needed basis. As tribal practices are approved, they are added to the AMH website. The panel carries out all of the functions of the TBPs effort. Currently, they are helping to get the practices to be billable under Medicaid, block grant, and other funding.

Since 2007, the panel has arranged an annual TBP Stakeholders Meeting that affords members of the tribal communities an opportunity to discuss their traditional practices with the panel. This tribal stakeholders' conference provides a platform for community members to describe their experiences with tribal practices and to propose that they be considered for TBP approval. Three or four practices are typically highlighted at the meeting. Presentations are given on the historical and current implementation of the practices, followed by an opportunity for discussion and questions. At these conferences, attendees are divided into groups that work together to draft TBPs. The panel members work with the tribal members to help transfer their deep-rooted oral histories onto paper for the purpose of drafting the TBPs. The last stakeholders meeting took place at the Native American Rehabilitation Association and had 50–70 people in attendance. The State Tribal Liaison noted that stakeholders regularly do not have enough time to collaborate with each other at these conferences; unfortunately, they usually do not have an opportunity to discuss practical methods for implementation of tribal practices. Stakeholders hope to do a better job of spreading the word about the annual meetings in the future to encourage greater participation. California and Washington have expressed interest in learning about Oregon's experiences.

Native Americans are very focused on talking about their practices instead of writing down their methods; it is not part of traditional culture to document methods and strategies on paper. Tribal populations are typically much more familiar with being taught orally what they need to learn. The panel is working to document practices while trying to keep the process culturally appropriate and sensitive. The opportunity to document traditional practices on paper at the annual meetings has been an important learning experience for both the tribes and AMH.

The state agency has funded the tribes since the 1990s, but it was not until the early 2000s that the agency began funding tribes' substance use disorder treatment programs. Currently, TBP receives $15,000 per year from the state to implement its approved programs, support the panel, and organize the annual meeting. Each tribe in Oregon has $50,000 per year carved out for them in the SABG, in addition to the $62,500 they each receive annually for Strategic Prevention Framework implementation.

Approved Tribal Programs

Since the inception of Senate Bill 267 in 2005, 20 TBPs have been approved. These programs provide a menu of options from which Native American communities can choose to best fit their needs.

One of the most widespread practices is the *Canoe Journey*, which is a metaphor for the journey of life. These canoe trips are free of alcohol, tobacco, and other drugs (ATOD). Participants require about 1 year of physical training to prepare for them, and the trips encourage community participation during a culturally relevant and personally meaningful experience. The protective factors that are bolstered during the Journey are interpersonal bonding and relationships, healthy beliefs, and individual resiliency. The Canoe Journey has evolved over the past several years of collaboration between state agencies and tribal populations, and it incorporates culture, wellness and creative expression for Native American women, men, and youth. Cultural education is the primary focus of the Journey, and is provided by tribal members and based in their own tribal history. Language, ceremonies, traditional stories, songs, and dancing are explored as a way of promoting personal and community resiliency and healthy lifestyles.

Another common TBP within the state is the *Horse Program*, which has been nominated for SAMHSA's Service to Science initiative. The Horse Program targets youth and adult criminal behaviors as well as substance use disorder and mental health issues, such as suicidal ideation and attempts. The program entails regular individually mentored and small group sessions that involve equine care, ground work, and horseback-riding lessons. Tribal youths and families have an opportunity to experience equine therapy, and they subsequently improve their attitudes, behaviors, emotion regulation, and sense of responsibility as well as their communication and relationship skills.

The *Cradleboard Program* targets partners who are planning, expecting, or recently gave birth to a baby. During the program, participants are taught the dangers of ATOD use before and during pregnancy and after giving birth, and they are educated about health concerns for newborns. Participants are also exposed to the tradition of cradleboards and why their use is an important part of Native American heritage. Parents finish making a cradleboard by the end of the program, and they learn about how preventing a baby from sleeping in prone position could reduce the risk of sudden infant death syndrome (SIDS).[46]

A widespread program throughout various tribes is the *pow-wow*, which is a native celebration of drumming, dancing, and singing for everyone in the community in a drug- and alcohol-free setting. The goal of this practice is to build cultural identity and increase connections to community. In particular, it promotes social cohesion, bonding, celebration, and transmission of

[46] Morantz, C. A. (2005). AAP releases new guidelines on preventing SIDS. *American Family Physician, 72*(11), 2368–2372.

culture to younger generations. Some pow-wows focus specifically on substance use disorder treatment and recovery, providing participants with a support network.

The *Round Dance* is a traditional practice that is held to honor each other's existence. The Dance provides an opportunity for various tribes to convene and sing and dance to traditional honor songs and prayers. Native Americans of all ages are welcome to participate in the Dances, as they provide safe, alcohol- and drug-free environments in which families and communities can bond with each another. Cultural education is a primary focus of this program, as tribal members can share their history, language, ceremonies, and stories.

Lessons Learned

The tribal communities and the state have learned from each other since they started implementing TBPs. The state agency learned about the different ways in which Native Americans evaluate programs, which are often opposed to the dominant culture's methods. The tribal means of categorizing and capturing information is much more oral and not document-based, and the processes for how programs are implemented are much more in-depth. AMH has acknowledged and accepted the different methods of the tribes and is willing to accommodate the processes required to continue efforts. AMH recommends that other states that might be considering a TBP program should collaborate with tribal authorities in their respective locations. They point out that states that fund tribes and already have a relationship with tribal populations may be close to working toward recognizing and funding TBPs in their state.

The tribes in Oregon have used what at first was a skepticism-inducing Senate Bill to help build a stronger relationship with the state. Through the TBP process, tribes are finding the strength to come together as a means of overcoming historical trauma. Considering the delicate history between tribes and the government, the efforts taking place now are bringing healing and hope to tribal members. The TBP process has afforded Native Americans an opportunity for cultural restoration.

Conclusions

In 2012, the SAMHSA Treatment Episode Data Set showed 5.1 percent of substance use disorder treatment admissions in Oregon were American Indian/Alaska Native.[47] According to the state's 2013 Substance Abuse Prevention and Treatment Block Grant Implementation Report, 9.1 percent (14,000 people) of those provided with personal prevention services were American Indian/Alaska Native.[48] Although Native American substance use disorder prevention and

[47] Substance Abuse and Mental Health Services Administration. (2012). *Substance abuse treatment admissions, treatment episode data set*. Retrieved from http://wwwdasis.samhsa.gov/webt/quicklink/OR12.htm

[48] Oregon Health Authority, Addictions and Mental Health Division. (2013). *SAPT Block Grant implementation report*. Retrieved from http://www.oregon.gov/oha/amh/amhpac/Documents/2013%20SAPT%20BG%20Implementation%20Report.pdf

treatment are priorities in Oregon, it is important to note currently more Native Americans adults per 100,000 people abstain from alcohol than any other race.[49]

The TBP Panel will soon begin rewriting the Approved Tribal Programs so that they uniformly adhere to one template, which would make implementation by tribes more streamlined. The next task for the panel is to develop a Medicaid reimbursement coding system, which would allow participation in Tribal Best Practices to be considered part of a billable activity on an individual's treatment plan. These initiatives will make the TBPs even more appealing to Native Americans throughout the state.

The relationship between Oregon's tribes and the state and federal governments has historically been strained. However, the adoption of a Tribal Best Practices system to accommodate the needs and beliefs of Native Americans has helped build a stronger relationship between the two entities. The collaboration between the state and tribes and the role of the TBP Panel has led to a better understanding of each other. The traditional values of tribal populations are being respected while a standardization of best practices is being developed. Other states can learn from Oregon's efforts to work with the tribes and help continue the prevention and treatment of substance use disorders among Native Americans.

[49] Substance Abuse and Mental Health Services Administration. (2010). *Substance use among American Indian or Alaska Native adults.* Retrieved from www.samhsa.gov/data/2k10/182/AmericanIndian.htm

Oregon

Types of Evidence-Based Practices (EBPs) Supported by the State Behavioral Health Agency (SBHA)

The Addictions and Mental Health Division (AMHD) of the Oregon Health Authority is currently supporting the provision of a number of EBP services for individuals with mental and substance use disorders (M/SUDs). Over the past 3 years, Oregon has reported to SAMHSA's Center for Mental Health Services (CMHS) Uniform Reporting System on the number of adults receiving four different mental health EBP services and the number of children receiving therapeutic foster care (Table A-3).

Table A-3. Number of Children and Adults Receiving Evidence-Based Practices in Oregon, 2011–2013

	Individuals Served, N			Individuals With SMI Receiving EBP, %			Fidelity Measured
Adult EBP Services	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**	**2013**
Supported Employment	850	781	968	1.3	1.2	1.4	Yes
Assertive Community Treatment	559	611	621	0.9	0.9	0.9	No
Family Psychoeducation	130	163	2,566	0.2	0.2	3.7	No
Medications Management	21,453	22,776	20,926	33.9	33.9	29.8	No
Adults with SMI	63,204	67,189	70,225				
Child and Adolescent EBP Services	**Individuals Served, N**			**Individuals With SED Receiving EBP, %**			**Fidelity Measured**
	2011	**2012**	**2013**	**2011**	**2012**	**2013**	**2013**
Therapeutic Foster Care	80	57	40	0.2	0.2	0.1	No
Children with SED	35,335	30,854	33,815				

Abbreviations: EBP, evidence-based practice; SED, serious emotional disturbance; SMI, serious mental illness
Source: Substance Abuse and Mental Health Services Administration Uniform Reporting System Data

The AMHD defines EBPs as—

> Programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence and the values of the individuals receiving the services. These programs or practices will have consistent scientific evidence showing improved outcomes for clients, participants or communities. Evidence-

> based practices may include individual clinical interventions, population based interventions, or administrative and system-level practices or programs."[50]

Using this definition, Oregon has published a list of over 100 approved EBPs for mental health and addition services.[51]

How the State Supports EBPs

Oregon has several approaches that have moved the state forward in providing EBPs. An initial impetus for EBPs in Oregon was a law passed by the State Legislature in 2003 that required the SBHA to expend a percentage of its budget for provision of EBP services.[52] This law mandated that the agency initially spend 25 percent on EBPs; this was then phased up to 50 percent and then to 75 percent of state funding.

Oregon's AMHD originally applied a broad interpretation and implementation of the statute, which spurred the adoption and growth of statewide EBP utilization in many service categories. The intent of the law, however, was to reduce reliance on incarceration, reduce recidivism, and reduce utilization of emergency mental health services through implementation, adoption, and use of EBPs at a statewide level. The AMHD changed its approach to be more specific and consistent with the intention of the statute in 2008.

In recent years, Oregon found that the law was problematic because it was very difficult to capture (count) the funding for EBPs. Collecting data was cumbersome, and it led the AMHD to re-review the law. They realized that they could report to the legislature (related to the mandate) only on certain types of services. In 2010, the AMHD reported to the Legislature:

> After participating in data gathering for the November 2008 ECO Northwest report Costs and Participation for Selected Evidence-Based Programs in the Criminal Justice System, AMH staff reviewed the final report and realized that the process that had been used for designating populations to be covered by [Oregon Revised Statutes] ORS 182.525 was not sustainable. AMH worked with the EBP Steering Committee and the other covered agencies to revise the approach to collecting the data in order to better align with the intended goals of ORS 182.525, reduce the propensity of a person to commit a crime, reduce recidivism and reduce the use of emergency mental health services. The new

[50] State of Oregon Addictions and Mental Health Division. (2007). *Operational definitions for evidence-based practices*. Retrieved from http://www.oregon.gov/oha/amh/ebp/ebp-definition.pdf

[51] State of Oregon Addictions and Mental Health Division. *AMH approved evidence-based practices.* Retrieved from http://www.oregon.gov/oha/amh/Pages/ebp-practices.aspx

[52] Oregon Revised Statutes, 182.525. *Mandatory expenditures for evidence-based* programs. Retrieved from http://www.oregonlaws.org/ors/182.525

process is more consistent with that used by the other state agencies covered by the statute.[53]

Oregon has developed a list of EBPs and criteria to determine whether a practice is an EBP. The document was designed to allow Oregon to identify what meets its definition, particularly to answer a provision in a law that called for tracking expenditures on EBPs. Any item that was tracked as an expenditure needed to be on the approved EBP list. As Oregon has moved away from the state-supported funding model, the EBP statute has become less significant. Providers occasionally want to add new services to the list of EBPs. This list currently is used primarily as reference material.

When Oregon first developed their list of EBPs, they encountered resistance from providers and clinicians, who advocated for their particular existing practices and wanted to ensure that they were on the list. For example, there were some concerns from Native American tribes who wanted the state to acknowledge the value of their cultural practices (see separate case study on this topic). The AMHD codesigned a separate process for culturally validating best practices with the tribes as an alternative to the EBP mandate. This process lead to an annual summit on evidence and culturally validated practices and forged new partnerships around this topic with Oregon Health and Science University, juvenile crime prevention stakeholders, and others. Occasionally, Oregon is contacted by programs wanting to add a new service to the list of EBPs.

Oregon was a pilot state for the testing and development of SAMHSA's EBP toolkit for Supported Employment. Four or five sites in Oregon piloted Supported Employment. Participation in development of the toolkit made Oregon appreciate the effort necessary to implement EBPs, measure their success, and ensure the value of fidelity monitoring. Supported Employment currently is not offered statewide in Oregon, but the SBHA is working to make the services available.

Early Assessment Support Alliance (EASA) is an early psychosis treatment program in Oregon for young adults experiencing their first symptoms of psychosis.[54] The EASA program seeks to help these individuals before their psychosis creates problems in their lives. The model builds on experiences of an early psychosis program first developed and tested in Australia. The work and testing of this service began as a local effort by a region in Oregon. The regional group invested in consultation and development of the model and then approached the state for funding to support it. With state approval and funding, the intervention has demonstrated positive results, and Oregon is now supporting the statewide expansion of that program.

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[53] State of Oregon Addictions and Mental Health Division. (2010). *Biennial report to the Legislative Assembly detailing progress on the adoption and implementation of evidence-based practices for mental health and addiction treatment and prevention services*. Website. http://library.state.or.us/repository/2014/201404221310292/2010.pdf

[54] Early Assessment Support Alliance. Website. http://www.easacommunity.org/

Financing EBP Services

Oregon sets some restrictions on billing for EBP services. For example, for providers to bill either Medicaid or state general funds for providing some EBPs such as Assertive Community Treatment and Supported Employment, they are required to meet a certain level of fidelity. To measure the fidelity, Oregon has contracted with a group of Centers of Excellence, which conduct independent fidelity reviews. The Centers of Excellence are a mixture of university-led centers and provider organization-based centers, which include Portland State University and Oregon Health and Science University. Initially, Oregon uses block grant funding to help develop and implement EBPs. Once the providers are successful in providing the EBP, the SBHA has worked with the Oregon State Legislature to include funding of the EBP as part of the SBHA's budget. Once the EBP is running, Oregon aims to have EBPs supported as much as possible by Medicaid.

Parts of some EBPs may not be fully billable under Medicaid or commercial insurance. For example, one gap in insurance coverage experienced in Oregon was for young adults, who often had no health insurance. The expansion of insurance to cover young adults up to age 26 on their parents' insurance and the expansion of Medicaid will help pay for these services to reduce this insurance gap. However, parts of the EASA service package will not be billable to Medicaid or commercial insurance, so the model will continue to require state dollars to fund. It should be noted that some services are not billable: outreach work to identify individuals, some of the work with families, travel, and other community education. Oregon does not have separate Medicaid billing codes for particular EBPs, with the exception of ACT and Supported Employment.

After the recent Sandy Hook tragedy and other high-profile unfortunate incidents involving individuals with mental illnesses, the Oregon Senate President made improving access to mental health a priority for the state. The Senate President asked the AMHD to identify their gaps in service delivery and what they needed. These unfortunate events have led to an increase in the AMHD's budget, with a focus on provision of EBP services.

State Supports for EBP Training of Providers

Training is usually funded through Oregon's Centers of Excellence. Supported Employment and ACT are contracted with a provider organization, which sets up the Center of Excellence. Fidelity measurement for some EBPs is provided as part of their Centers. It is a selling point to providers to offer this training and fidelity measurement for some EBPs without charge.

In some cases, Oregon has funded training services during the rollout of a new EBP; however, as the providers become more stable, the state expects the provider to fund the services and ongoing training for the EBP through billing. For ACT and Supported Employment, Oregon allows providers to use a provisional certification to bill the state while they are training to reach the required fidelity level. This provisional approval applies for 1 year, at which point providers must reach the fidelity requirement.

Effects of the Affordable Care Act Expansion of Insured Populations (Expanded Medicaid and Marketplace Insurance) on EBPs

Prior to Affordable Care Act, behavioral health services were billed to Medicaid through the Oregon Health Plan, which is their managed care plan. Oregon had two separate service plans: one was for individuals with major behavioral health needs who had private insurance and the other was for individuals who had Medicaid. With the Affordable Care Act and Medicaid Expansion, Oregon now has only one service package for Medicaid.

With the implementation of the Affordable Care Act, Oregon went through its own state health system transformation. The state shifted from a managed care system with mental health as a carve-out service, with substance use disorder and physical health in a separate system. Oregon now has a coordinated care system where nearly all services are included; dental services will be included in the future.

With the expansion of Medicaid, Oregon's SBHA was asked what kind of savings they would have when services for clients who were previously uninsured are now covered by expanded Medicaid. Oregon developed some estimates of the potential cost savings, but the Oregon Legislature ultimately decided not to adjust downward or remove funding from the state level. They directed mental health agencies to use state funds to expand services such as early psychosis, Supported Employment, Parent-Child Interaction Therapy (PCIT), and expansion of ACT statewide. They also received funding from Medicaid to expand parent/child interaction therapy.

Oregon is concerned that private health insurance plans may not cover expensive EBP services; in particular, obtaining coverage for children's services proves to be a challenge among private insurers. Oregon has a strong parity law, and they feel that the new federal parity statute will help ensure the inclusion of behavioral health benefits in new insurance plans.

Measurement of EBP Outcomes

Oregon is moving from paying for the delivery of services to paying for the delivery of outcomes. The state has identified some specific metrics for outcomes relate to practices; however, there are no metrics tied specifically to individual EBPs. In time, the state will roll out a set of benchmarks backed by general funds. The state is awaiting the rollout of a new data system to support these new benchmarks. An example of a practice with performance matrix is the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) and identification of benchmarks.

The new coordinated care organizations (CCOs) will have a global set rate. Within this budget, it is up to the providers to work with the CCOs to determine an appropriate pay-for-performance model. For CCOs to be eligible for incentives, they must achieve certain benchmarks. The

AMHD wants CCOs to address the full spectrum of health care. This is in line with Oregon's philosophy on allowing more local control.

Barriers to EBP Implementation

The following barriers have been identified:

- The rates provided by the state do not always meet the cost needs of providers.
- There are cultural barriers surrounding partial investment in services (such as providing a partial implementation of ACT), including a belief that a provider can use parts of ACT and receive the full results expected if ACT is conducted with fidelity to the model.
- For some EBPs, it is difficult to bill for all of the costs. There are often up-front costs that are difficult to cover. Provisional certification allows providers to bill as they are developing their services (for 1 year) to the level that meets fidelity.
- Many components of EBP training are not covered in professional degree training and need to be provided while clinicians are on the job. For example, not all schools of psychiatry, psychology, and social work are teaching their students EBPs as part of their professional training.

Lessons Learned

Oregon has found that no one approach will work for supporting and moving EBPs forward. Overall, the EBPs need financial and cultural support from agencies, and this requires a variety of approaches. The approach must fit the needs of each EBP. Oregon's EBP law helped galvanize their actions.

Rhode Island

Types of Evidence-Based Practices (EBPs) Supported by the State Behavioral Health Agency (SBHA)

Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (DBHDDH) is currently supporting the provision of a number of EBPs for individuals with mental and substance use disorders (M/SUDs). The services include Supported Employment, Supported Housing, trauma-informed care, family psychoeducation, medication-assisted treatment for substance use disorder, and medication-assisted treatment for alcohol use disorder. In addition, the DBHDDH recently transitioned from supporting statewide provision of Assertive Community Treatment (ACT) services into a new behavioral health home program. Over the past 3 years, Rhode Island has reported to SAMHSA's Center for Mental Health Services (CMHS) Uniform Reporting System on the number of adults receiving five different EBP services for mental health (Table A-4).

Table A-4. Number of Adults Receiving Evidence-Based Practices in Rhode Island, 2011–2013

	Adults Served, N			Adults with SMI Receiving EBPs, %			Fidelity Measured
Adult EBP Services	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**	**2013**
Supported Housing	362	430	403	2.4	2.8	2.6	No
Supported Employment	540	514	828	3.6	3.3	5.4	No
Assertive Community Treatment	1,258	--	--	8.4	--	--	--
Dual Diagnosis Treatment	2,688	3,390	3,004	18.1	21.9	19.6	No
Medications Management	2,712	2,428	2,764	18.2	15.7	18.0	No
Adults with SMI	14,889	15,481	15,318				

Abbreviation: EBP, evidence-based practice; SMI, serious mental illness

Source: Substance Abuse and Mental Health Services Administration Uniform Reporting System Data

Penetration rate is defined as the percentage of adults with SMI who are served by the SBHA and receive ACT services. For many years, the DBHDDH was a national leader in supporting ACT services statewide, and they had with one of the highest penetration rates for ACT of any state. To support ACT services, the DBHDDH had a full-time staff person whose role was to focus on ACT. This individual was responsible for measurement of the fidelity of programs to the ACT model. A program needed to be certified by the DBHDDH as meeting fidelity to bill Medicaid for ACT services.

Over the past 2 years, Rhode Island has transitioned from supporting ACT services to behavioral health homes. The shift was driven more by financial impacts than by clinical issues. Over time, the DBHDDH saw issues with ensuring fidelity and increasing costs to delivering ACT services. The DBHDDH did not feel that they had sufficient resources to support ACT with full fidelity. They decided to focus on a more flexible delivery of services that could be better accomplished through a behavioral health home model.

When health homes emerged as a new option through the Affordable Care Act, the DBHDDH model moved to incorporate health homes and shift the focus of service to the Whole Health model. The care coordination, behavior management, and community outreach aspects of care were transferred from ACT into the health homes model. Other ACT services, such as crisis interventions, still exist as a non-health home intervention service. The transition from ACT to health homes split clinical services from community services; ACT incorporated everything into one service, whereas health homes split the model. This required the DBHDDH to provide guidance on clinical services rather than health home services.

The shift to behavioral health homes has led to more emphasis on nurse time and physician time and less emphasis on case management services. The clinical-level team lead is responsible for bridging the health homes and clinical portions of the two teams. This means that some providers may need to shift their staffing by eliminating some positions and hiring different staff. Most providers were able to manage by shifting from within their existing staff structure.

How the State Supports EBPs

The DBHDDH has used state employees to help providers implement EBP services, coordinate training, and monitor fidelity. Currently, the DBHDDH has one staff person who is responsible for both their Employment First (Supported Employment) and Housing First (Supported Housing) initiatives. Prior to the transition to behavioral health homes, the state had a full-time staff person who supported the implementation, training, and fidelity of ACT teams.

The department has used a combination of state dollars and a Request for Proposal (RFP) process to incentivize providers to implement EBPs. For example, the department recently had a project to identify EBPs for clients with co-occurring M/SUDs, and then they used an RFP process to identify providers for these services. This EBP identification process was driven by data on outcomes and effectiveness.

Financing EBP Services

The state works to use Medicaid funding (either through the Rehabilitation Option or through a managed care carve-out program) whenever possible. Some EBP services are not Medicaid reimbursable and are supported by state general funds and SAMHSA Block Grant funds.

Supported Employment is a Medicaid-billable service under the state's Rehabilitation Option. It is part of the benefit package available through their carved-out managed care system. The state

Office of Rehabilitation Services may also bill Medicaid for the Supported Employment services they provide. The DBHDDH has an initiative to help consumers gain employment and maintain Medicaid benefits.

For Supported Housing, Rhode Island has a Housing First initiative that provides case management wraparound services where the individual is placed in housing first, without a requirement to be active in other services. The same staff person is in charge of the Housing First and Employment First initiatives. The DBHDDH has a contract to provide case management and wraparound services for individuals in Housing First (where Medicaid will not pay for these services). The DBHDDH also has funding for Psychiatric Rehabilitation residences and group homes. Placements of mental health consumers into group homes are conducted by a staff member based on applications, and the staff member keeps track of available housing slots. Housing First is not a Medicaid-billable service; therefore, Supported Housing programs are funded by grants. Group homes, except for room and board, are Medicaid billable. The DBHDDH also uses a combination of state funding and U.S. Department of Housing and Urban Development (HUD) funding to pay for housing for consumers.

Health homes are billed as a bundled monthly rate. For the first eight quarters of health home implementation, Rhode Island uses the Affordable Care Act's Section 2703 90-10 federal government match rate for health homes. After eight quarters, this reverts back to Rhode Island's regular state Medicaid match rate. The DBHDDH used other funding streams to incorporate health home training into existing state contracts with providers.

With the shift from ACT to health homes, there was no new money to put into the state system, and the net financial impact was neutral. However, Rhode Island has observed that some behavioral health providers have made more and others have made less, depending on their structuring of service delivery. The state worked extensively with Medicaid and providers prior to the State Plan Amendment to prepare for the transition to health homes. The state's billing structure already was primarily in place and only required a little amending to apply it to health homes.

State Support for EBP Training of Providers

The recent transition from ACT to health homes was supported by a state implementation planning team. The state used a training contractor and took steps to ensure that a billing structure was in place for the state to absorb costs for the transition. Health homes were incorporated as part of ACT in the initial implementation.

The ACT teams each had an employment/vocational and substance use disorder specialist as a member of the ACT team. This role was separated in the health home model, and Supported Employment is now billed as a separate service. This change was made to incentivize the provision of Supported Employment services. Supported Employment is provided statewide.

Rhode Island maintains yearly training with certification on the Individual Placement and Support (IPS) model for Supported Employment providers.

Rhode Island has worked with the New England Institute for Addiction Studies. They provide training that rotates around the region. This organization has developed an EBP and workforce tool for providers in the New England region.

The University of Rhode Island conducts evaluations for the state. The DBHDDH has a good relationship with Rhode Island College to incorporate EBPs into their curriculum, but the Department has less engagement on the psychiatric side. Rhode Island would like to collaborate more with the major universities in the state, particularly the University of Rhode Island and Brown University.

Effect of the Affordable Care Act Expansion of Insured Populations (Expanded Medicaid and Marketplace Insurance) on EBPs

Rhode Island was one of the first states to expand Medicaid as allowed under the Affordable Care Act. As part of this expansion, the state shifted services into a Medicaid Managed Care Program. The DBHDDH worked extensively with providers using both state funds and costs not otherwise matchable (CNOM) funds to help consumer transition to insurance. CNOM funds are available through the 1115 Medicaid Waiver; they allow federal match for certain services for individuals who are not otherwise eligible for Medicaid. The DBHDDH found that this was a successful effort and estimates that up to 60 percent of consumers who had previously been funded by the state are now moving into the expanded Medicaid benefit. The DBHDDH met with providers to help them prepare for the shift to managed care.

As of January 2014 some services that had previously been paid by state funds are now able to be billed to Medicaid (e.g., services such as substance use disorder residential care). The DBHDDH has developed a list of services that Medicaid managed care networks cover, and this list determines what providers can bill to Medicaid. The DBHDDH has worked with providers directly as a liaison between providers and plans about how to incorporate health homes and psychiatric rehabilitation homes into their services. The DBHDDH will monitor the contracts and reports from their managed care organizations to measure changes in service delivery.

Rhode Island believes that some but not many of their consumers with M/SUDs have signed up for subsidized insurance through the Health Insurance Exchange. Commercial insurance plans have not been covering most of the EBP services that are supported by Medicaid and state funds. The DBHDDH has received reports from their behavioral health providers that private insurance plans do not cover supplementary services such as health homes and Supported Employment.

Commercial insurance in Rhode Island will pay for certain mental and substance use disorder services. Difficulties have existed in finding commercial insurers with methadone maintenance coverage or coverage for some of the long-term services that Rhode Island has in place for the

population with serious and persistent mental impairment (SPMI). Rhode Island is seeking continued use of CNOM funding to provide these services for individuals under 200 percent of the federal poverty level who are not eligible for Medicaid and are underinsured.

Measurement of EBP Outcomes

The Rhode Island Behavioral Health On-Line Database (RIBHOLD) is a database of client information that provides outcomes data. This system is not set up to measure specific outcomes related to EBPs except for medication assisted treatment; however, the system collects data on the providers' overall population-based outcomes. The state also monitors outcomes for Supported Employment, and the new health homes initiative will get more data, such as hospitalization rates, substance use disorder treatment, smoking cessation treatment, and various medical measures.

Barriers to EBP Implementation

Rhode Island has encountered the following barriers:

- Because Rhode Island is a small state, some providers have a low number of consumers and do not have a critical mass to provide some EBPs (i.e., they may not have enough consumers to justify adequate staffing for an EBP at all centers). Combining resources would allow additional implementation of EBP services for the entire state, but they have a decentralized system.
- The different payment sources used to pay for services make EBP implementation difficult. Providers need to determine what source will pay for each service.
- Rhode Island has a high turnover of trained staff. If a key trained staff member leaves a provider, the provider may then lack qualified staff to offer that EBP until the person is replaced.
- There was some resistance from some providers to the shift from ACT to health homes, particularly because transitioning models caused a break-up of ACT teams at some provider facilities. Some providers were very receptive and ready for change, whereas others were more hesitant.

Lessons Learned

Rhode Island highlights the following lessons learned:

- Collaboration and strong relationships with Medicaid are important. Rhode Island had willing partners in the Medicaid Office and Department of Health. There were forward-thinking, cabinet-level agency leaders who were able to see opportunities in revising the system and in collaboration across agencies. Rhode Island also had very good relationships with provider groups; they were all able to work together to improve the system.
- Never underestimate the need for communication.

- Include consumers, payers, and providers in planning. The DBHDDH could have used more consumer and family group coordination in implementing EBPs. Consumer recovery groups have actively worked to get services covered.
- The staff time needed to implement EBPs and measure fidelity cannot be underestimated. The EBPs were successfully implemented when the DBHDDH was able to hire a full-time staff person to lead this effort.

Appendix B: Case Studies on Improving Behavioral Health Business Practices

Arizona

Background

Arizona is a Behavioral Health Managed Care state that integrated the responsibility for public mental and substance use disorder services in the early 1980s. The Division of Behavioral Health (DBH) partners with Medicaid to fund behavioral health services. They have the fifth-highest rate of gross expenditures on community-based services. This partnership has also allowed them flexibility in how they spend their SAMHSA Mental Health Block Grant funds.

Contracting Services

Contracts for services are developed by the DBH through intra-governmental agreements with other state agencies. The managed care entities are responsible for providing these services. Through the contracts, the managed care entities maintain separate accounts for block grant funds, state general funds, and Medicaid funds. This separation of accounts makes it more difficult for the DBH to blend funds to support services and to determine how much funding is needed to provide services for an individual consumer. However, the separation of accounts is useful in managing the providers.

Mental Health Block Grant Funds

The Mental Health Block Grant Funds represent 0.5 percent of the state's annual budget for mental health. These funds are paid through contracts managed by the state's managed care entities. They support short-term, community-based services, such as Supported Employment and Supported Housing. The state uses Maslow's hierarchy of needs as a guide to help them identify safety-net services. Maslow's hierarchy of needs postulates that people need to satify their physiological survival needs and safety needs (shelter, clothing, food, income) before they can address higher level needs such as self-esteem and self-actualization.

Managed Care Organizations

Arizona did not want a single statewide managed care program; rather, they set up their system with multiple managed care entities operating across the state to help them better understand and address issues related to serving rural and tribal areas. There are four managed care entities in Arizona that operate across six geographic service areas. Mercy Maricopa operates only in Maricopa County; the others operate across five service areas in the state. Mercy Maricopa's contract has been renewed. The contracts covering the other service areas were open for bid through a Request for Proposal (RFP) process. The state will use the results to reduce the number of service areas to three, with no single managed care entity responsible for more than one region.

Commercial Insurance
Arizona chose its State Employee Insurance Plan as the benchmark for insurance available through the state's Health Insurance Marketplace. This plan is very comprehensive but does not include coverage for a variety of community-based services, including Supported Housing, Supported Employment, and Assertive Community Treatment, which are covered by Medicaid.

The DMH has additional funds to provide these services for individuals covered by commercial insurance. Providers are required to conduct financial eligibility screens of their populations twice per year in an attempt to better understand the size of the population covered by commercial insurance subsidized by the Affordable Care Act. The DMH does not yet fully know the size of this population. They are also requiring community-based mental health services to enroll uninsured individuals during encounters at emergency rooms.

Billing and Compliance
All billing is done through the provider system to the managed care entities and then delivered to Medicaid for payment. Medicaid also soon will begin processing the billing of state-funded services to avoid duplication of payment. The DBH uses the Medicaid billing system to track data. Through this system, they are able to obtain demographic data regarding who receives services. This allows the DBH to develop performance measures and monitor outcomes for Healthcare Effectiveness Data and Information Set (HEDIS) and the block grants. This approach requires dedication and a strong partnership with Medicaid.

The DBH was able to use this billing system to identify that its consumers were extremely high users of Medicaid for behavioral health and physical health services. As a result, the legislature and governor provided the DBH with an additional $200 million to develop a managed care entity that also integrates physical health care.

Health Information Technology
Arizona was the first state to implement a statewide Behavioral Health Information Exchange. The Exchange allows behavioral health to have a powerful presence in state and national discussions. The Exchange contains data associated with Medicaid's meaningful use and the Continuity of Care document.

Providers in the state all use their own electronic health records (EHRs) based on standards set by the managed care entities with which they work. Most of these EHRs meet Stage 1 and 2 meaningful use standards. EHRs in the state can connect to each other and—depending on established permission—clinical records can be shared. The providers with the most sophisticated EHRs are primarily in Phoenix and Tucson (the state's major urban areas), because they are able to maximize economies of scale by partnering with other providers. However, 90 percent of Arizona is rural, remote, and sparsely populated. The providers who serve these areas struggle to implement EHRs that meet meaningful use standards. The managed care entities

build the costs of EHRs into their contracts, allowing for a four percent profit for EHR implementation and up to eight percent for operating an EHR.

Barriers to Changing Business Practices

It has been a challenge for the DBH to address prevention with block grant funds. They would like flexibility to use these funds to support child welfare services, especially in cases of neglect, which is seen as a precursor to child abuse. By providing prevention and intervention services, the DBH believes they can limit the need for mental health services in the future and decrease interactions with criminal justice.

Antiquated laws hinder the development of more robust health information data networks. Statute 42 CFR requires consent for each release of information, which means that providers and clinicians are not able to share data about clients with substance use disorders on the Health Information Exchange. The antiquated rules limit the providers' ability to treat the whole person and perpetuate stigmas associated with treating behavioral health by limiting access to all of an individual's medical information.

Lessons Learned

Constant dialog and collaboration with Medicaid is important to make systems work. The DBH has worked to ensure a strong relationship with Medicaid. Their collaboration is successful as a result of constant communication between the two agencies, the use of coordinated contract management between the systems, and a systematic and holistic approach to behavioral health that relies on a robust and transparent data system.

Learning from other systems is important to help with system changes. As the last state to accept Medicaid, Arizona attributes its success in implementing Medicaid Managed Care to its ability to learn from others. Arizona began the implementation of Medicaid with a managed care approach and has improved their system over the past 30 years.

Arizona found that their strong HIE system and other data capacities are critical to their system's functioning. The appropriate use of health information technology is the backbone of a successful system transformation.

Kentucky

Background

Kentucky is one of the few states that expanded Medicaid and built a state Health Insurance Marketplace Exchange. Under the Affordable Care Act, 450,000 new enrollees out of a population of 4.4 million signed up for insurance through the state's Insurance Exchange. Most of those who enrolled will be covered by the Medicaid expansion. An analysis commissioned by the state and reported in a white paper estimated that Kentucky could realize $65 million in savings on behavioral health expenditures through the expansion of Medicaid coverage.

There have been five managed care organizations (MCOs) operating in the state since 2013 and a system of 14 regional mental health boards that bill services to Medicaid. Independent mental health practitioners who previously could not bill Medicaid can now do so.

Contracts to Providers

As a result of the Affordable Care Act, Kentucky has modified its approach to financing behavioral health services and has established new contracts with the 14 regional mental health boards. Starting July 1, 2014, the contracts will cover only services that would not otherwise be covered by Medicaid or private insurance. Kentucky has used the SAMHSA block grant model to determine which services will be covered by the contracts. The contracts generally cover crisis services, prevention services, services for those with a serious mental illness or serious emotional disturbance, and substance use disorder treatment. The expansion of insurance coverage and the billing that will result is estimated to bring a potential $110 million in revenue to providers in Kentucky.

Because of Kentucky's expansion of Medicaid and submission of a State Medicaid Plan Amendment, potential "savings" were identified related to behavioral health services. The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has had its budget reduced accordingly by $21 million in state fiscal year (SFY) 15. Starting January 2014, Kentucky began to advise providers to increase services because the new changes came into effect on July 1, 2014. Most providers will receive cuts of $700,000 on average; one provider will lose close to $4 million in flexible Community Care and Support funding. The DBHDID had to take an internal cut of $9 million in SFY 14, and they will lose $9 million in additional cuts in SFY 16.

Managed Care Organizations

Kentucky has five MCOs: four provide statewide coverage, and one is a nonprofit MCO in the Louisville area. The payments to the MCOs are structured as per member per month. The MCOs negotiate contracts with the regional mental health boards. The regional boards have contracts with each of the five MCOs. The regional boards also have contracts with the DBHDID for services that are not covered by Medicaid or private insurance.

Medicaid rates are set by the DBHDID for Medicaid services and are published as fee-for-service rates. MCOs use the rates as a ceiling for establishing rates with their providers for services. Kentucky is monitoring one potential issue. Because of the level of some Medicaid rates, many providers have noted that it is difficult to pay for some services because they do not cover the cost of specialists (such as psychiatrists). This problem is exacerbated by the fact that state funds cannot be used to cover shortfall.

Health Insurance Enrollment

The regional boards are reaching out to people in their area and enrolling them in health insurance, because they will no longer be able to bill for services not covered by insurance, even if the individual is uninsured. This outreach was supported by the state at a rate of $45,000 per region.

Commercial Insurance

A quarter of those who signed up for insurance through Kentucky's Marketplace Exchange will have commercial insurance, but commercial insurance does not pay for many behavioral health services covered by Medicaid, such as mobile crisis services.

Block Grant Allocations

The allocation for the Mental Health Block Grant has stayed the same since the implementation of the Affordable Care Act. State general funds and Mental Health Block Grant funds are pooled for adults with serious mental illness (SMI) and children with serious emotion disturbance (SED) without insurance coverage. Providers are restricted to billing for four evidence-based practices (EBPs): Assertive Community Treatment, Supported Employment, Peer Support, and Supported Housing. The remaining funds are used for those without coverage or for services not covered by insurance, such as crisis respite.

Each of the state's regions had a Substance Abuse Prevention and Treatment Block Grant and state general fund allocation, which represented roughly $8 million of general funds and $20 million of block grant funds. These funds are allocated by population. With Affordable Care Act implementation for individuals without insurance, the substance use disorder funds provide a basic level of services with the exception of residential services, which are not currently covered. By January 2015, all substance use disorder providers will offer intensive outpatient treatment.

Health Information Technology

Ten of the 14 regional boards have electronic health records (EHRs), using systems from five different vendors. The state's data system supports a monthly upload of client- and event-level data to the University of Kentucky. Data reporting is not tied to billing. The state was part of a national group working to create discharge summary (continuity of care document) capability.

Through the Governor's Office of Health Information Technology, a regional HIE has been established. The Office is attempting to get all provider and regional boards to join.

Kentucky's DBHDID meets individually with MCOs every 6 weeks. MCOs are required by contract to provide data reports on behavioral health; however, because of time lag, there is a concern that DBHDID is not receiving usable data. Another barrier or concern is the quality of the data received. MCOs and the state agency do not use the same definition of SMI/disability and SED/disability to capture these data. The MCOs use diagnosis codes to identify SMI and SED status; regional mental health and mental retardation boards use diagnosis along with duration and disability status—information that is not available in claims data.

Relationship With Medicaid

The relationship between the DBHDID and Medicaid is becoming more integrated as they work together on regulations and the State Plan Amendment. The primary relationship is not between Medicaid and the DBHDID; rather, it is between Medicaid and the MCOs, because the Medicaid match goes directly to Medicaid and does not pass through the DBHDID. The DBHDID acts as an advisor to Medicaid.

Lessons Learned

Kentucky specifies that it is important to—

- Have clarity on service definitions and standards
- Have a strong relationship with Medicaid
- Ensure that the skill set of the staff matches the needs of the agency, especially regarding the oversight of the MCOs

Maryland

Background

In 1997, Maryland implemented an administrative service organization (ASO) that is responsible for paying claims as a carve-out service for individuals who are uninsured or covered by Medicaid. The ASO paid for services previously funded by Medicaid, state general funds, and the Mental Health Block Grant, including specialty psychiatric care.

Substance use disorder (SUD) services were included in the 1115 waiver service package, and waiver participants were the responsibility of the MCOs. Many of the individuals requiring SUD services were childless adults who were not eligible for Medicaid, which limited billing to MCOs for substance use disorder services. The Substance Abuse Prevention and Treatment Block Grant was separate from the managed care system and managed by the single state agency (SSA) for substance abuse services. The SSA used outside contracts for most services. With the advent of the Project AIDS Care (PAC) waiver in 2006, some of the individuals in need of substance use disorder services became eligible, and provision of Medicaid-funded services for substance use disorders began to increase.

Changes to Business Practices

Maryland reviewed their system to look at integrating mental health, substance use disorder, and physical health care, and they decided that the integration of services would be through their ASO. The integration began July 2014. Funding for Medicaid-funded mental health services will move from the mental health authority to the Medicaid agency. In January 2015, a new ASO contract will begin. The goal is to create closer integration of mental health, substance use disorder, and Medicaid. The new funding model is designed to help Maryland improve the relationship between behavioral health and physical health care.

The ASO will be responsible for giving providers information about the Medicaid eligibility status of consumers seeking service and for notifying providers when an uninsured applicant may be eligible for Medicaid and should be referred to the appropriate eligibility authority. This strategy has proven effective in mental health over the past in ensuring the maximization of Medicaid funding and limiting the need for state funding.

Residential substance use disorder services, school-based services, court-ordered services, and other services that are not Medicaid reimbursable will be funded at a reduced level through the state's 24 jurisdictions. The jurisdictions will ensure that they do not wrongly use funds reserved for the uninsured. These jurisdictions either provide the services directly or through outside contracts.

Expanding Medicaid
A large number of people who used the Maryland Health Insurance Marketplace qualified for Medicaid. Individuals receiving coverage from the Medicaid expansion qualify for the same benefits package as all other Medicaid recipients.

Block Grant Allocations
The block grant funds crisis services, hot lines, services in jails, and other services that do not lend themselves to fee-for-service billing. These are funded through contracts.

Health Information Technology
The new ASO will be responsible for collecting information on all mental and substance use disorder services, and it will replace the existing, separate data-collection systems. Maryland is helping the jurisdictions implement electronic health records (EHRs) to prepare for the new billing environment. They expect that 30 percent to 40 percent of the substance use disorder providers will become part of the network of commercial insurers.

Maryland has built compliance capabilities into the ASO contract, including spike reporting, outliers related to providers and participants, billing during holidays, and the global cost of care. There will also be on-site data audits.

Maryland was one of the first states to implement EHRs for physical health through the Chesapeake Regional Information System for our Patients (CRISP). Most of the large providers of behavioral health services have EHRs, but there are different systems for mental and substance use disorder providers. Most of the individual practitioners do not have EHRs. The substance use disorder providers will need an EHR that is compliant to bill Medicaid. For the mental health providers, CRISP has capability of providing information to providers when the consumer is admitted to an inpatient facility or an emergency room. The physical health care providers will be able to access the consumer's mental health history and input the information into his or her medical file. Providers will also be able to obtain the patient's current medication information from the pharmacy benefits manager.

Only one of the state psychiatric hospitals has an EHR. The other hospitals are waiting for the new system to be set up at the departmental level. Currently, they have a system that is linked to the state information system that tracks admissions, discharges, and pharmacy data, but it is not a full EHR.

Ensuring Service Quality
Maryland has had a mental health outcomes system since 2006 that is integrated into the ASO. It collects information on symptoms, client functioning, legal system involvement, living situation, and recovery measures. The data are collected at intake and every 6 months. These outcomes are used for service authorization, giving providers incentives to complete and submit the data for the measures.

Barriers

Maryland identified the following barriers:

- Maryland has been working to build the capacity to share information electronically among providers. However, the federal confidentiality statute 42 CFR impedes the provision of good quality care for individuals with substance use disorders. Providers cannot share data that are vital to the provision of care, such as data used for treatment planning. Federal requirements pertaining to confidentiality of alcohol and substance use disorder records (42 CFR Part 2) has been a barrier for substance use disorder treatment and service providers, because to comply with the law they cannot adopt the existing CRISP system.
- The churn of individuals between Medicaid and commercial insurance creates problems for billing and maintenance of services, because commercial insurance benefits often do not pay the same rates or cover the same services as Medicaid.

Lessons Learned

Maryland has found that it takes time and an extensive amount of work to do things correctly. The RFP and contracting process for the new ASO contract has been very time consuming.

Oklahoma

Background

In Oklahoma, there are two classes of providers: those with Department of Mental Health (DMH) contracts and those with Medicaid-only contracts. Oklahoma has a total of 100 DMH providers, 300 Medicaid-only providers, and 700 individual practices. The state has 14 community mental health centers (CMHCs); approximately 60 substance use disorder treatment providers, 14 of which are also CMHCs; 25 mental health residential care providers; and 15 providers that offer specialty services, such as those directed at individuals who are homeless and people with gambling addiction.

Expanding Medicaid

Oklahoma decided not to expand Medicaid. Most of the behavioral health consumers they serve are below the federal poverty level. Approximately 95 percent of these consumers would have been eligible for Medicaid had it been expanded.

Contracts to Providers

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has worked for several years to prepare state-funded behavioral health care providers for changes in the health care delivery system. In 2005, all state-contracted providers were required to have national accreditation and be Medicaid compensable. In 2009, the state phased in a requirement that all assessment, treatment planning, and psychotherapy be provided by a licensed staff member. In 2010, changes were made to the administrative rule to increase the focus on quality of care.

In 2010, the ODMHSAS statewide data system was merged with the Medicaid system to align reporting procedures and ensure that state and federal funds are only used when no other funding sources are available. Modifications have been made to ensure that clients receive the appropriate array and amount of services. In 2011, standards and criteria were established for comprehensive addiction and recovery centers that are very similar to the prerequisites of a CMHC. Consumers can quickly be assessed, engaged in treatment, and have immediate access to multiple levels of care regardless of geographic and programmatic barriers.

The ODMHSA, the Mid-America Addiction Technology Transfer Center, and the Oklahoma Substance Abuse Services Alliance (a provider organization) hosted the Oklahoma Changing Healthcare Landscape training. Substance use disorder treatment facilities responded to a readiness assessment. National leaders in health reform worked with the substance use disorder treatment providers to develop strategies to respond to regulatory, policy, funding, business, health information technology, and clinical challenges.

The ODMHSAS started a Learning Collaborative to help mental health providers become patient-centered health homes. The Learning Collaborative assists with workforce training and

responds to the need for a Health Information Exchange (HIE) for all providers. All providers must be linked to a Health Information Organization (HIO) and be able to exchange treatment data electronically within 12 months of becoming a health home.

All ODMHSAS contracts with providers require that state funds or grant funds passed through the ODMHSAS must be used as the payer of last resort. The Medicaid Management Information System (MMIS), which processes all state-funded and Medicaid claims, is comanaged by the ODMHSAS and the state Medicaid agency. To ensure that third-party and other revenues are maximized, the MMIS cross-references insurance databases to identify other sources of payment.

Managed Care Organizations

Medicaid behavioral health services in Oklahoma are fee-for-service only. There are no plans to change this status.

Commercial Insurance

Oklahoma's billing system is integrated with Medicaid and checks for third-party insurance eligibility. If there is third-party insurance, the provider will bill the commercial insurance. There are, however, some services that are not covered under the third-party liability (such as services for prisoners). The ODMHSAS has created a list of services against which their Medicaid billing system can be checked.

Providers are allowed to bill only one-twelfth of their allotment each month, although all services are paid on a fee-for-service basis. There is a hierarchy for which funds are spent first, beginning with state funds and then federal block grant funds. All rollover is carried into the next month.

Health Information Technology

The ODMHSAS operates 11 facilities, contracts with 120 nonprofit facilities, and oversees approximately 400 Medicaid-only facilities. The state-operated facilities use the NetSmart avatar—the first behavioral health electronic health record (EHR) to be certified for meaningful use. The ODMHSAS does not dictate the type of EHR that providers not operated by the state must use, but it does encourage the adoption of EHRs.

Each CMHC has an EHR, and many EHRs are in the process of being upgraded to meet meaningful use requirements. The Grand Lake CMHC was the nation's first behavioral health facility to qualify for meaningful use.

Oklahoma has one of the nation's longest-functioning HIEs. It was fully functioning before ODMHSAS providers joined HIEs, which welcomed behavioral health participation. All CMHCs currently have a contract with an HIE. The adoption of HIEs by the CMHCs proceeded slowly, because installing the technology was easier than changing the culture at the CMHCs related to data use. In addition, 342 individual clinicians are connected to an HIE.

The stringent requirements of statute 42 CFR Part 2 inhibits the linking of behavioral health records. All HIEs use an all-or-nothing approach, meaning that all of an individual's treatment record is shared or no part of it is shared. There is no consent registry, so it is impossible to determine which individuals have consented to share their information and whether the consent has an end date or is related to a treatment event.

Relationship With Medicaid

The ODMHSAS has reviews and audits to check for potential billing mistakes, fraud, and abuse. They are responsible for prior authorization of services for about 150,000 individuals per year receiving behavioral health services, and they are responsible for reviewing payments. They identify providers who were being paid for nursing care and set limits on how much each individual can receive for rehabilitation. There is a proposed limit to the number of hours that can be billed by clinicians per week. The ODMHSAS's billing compliance work is completed by a small staff, including four help desk staff, three or four programmers, and one data analyst. Previously, this work was conducted through an outside contract with a staff of 20 people for a cost of $8 million.

The ODMHSAS tracks each individual for information about what is paid by block grant, Medicaid, and state funds. The ODMHSAS has requirements related to business practices for providers:

> The facility shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to: Hardware and software, Security, Confidentiality, Backup policies, Assistive technology, Disaster recovery preparedness, Virus protection, Compliance shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

Lessons Learned

Oklahoma identified the following lessons learned:

- Technology is relatively easy. It is the culture change to use information and work across systems that is difficult.
- Many providers are intimidated by technology or by the idea of partnering with physical health care providers, which tend to operate differently. However, the largest barrier encountered is the longstanding belief that the confidentiality of behavioral health information is an essential element in delivering services and that sharing this type of information is contrary to best practice.

- The ODMHSAS has observed that some states are collecting less information in their billing system, relying instead only on claims data. They are concerned that outcomes of services may not be tracked in a robust manner.
- Because the ODMHSAS has a strong HIT system capacity, they are able to innovate quickly. A good HIT system allows agencies to better inform legislators with data, outcomes, and summaries. This information allows mental health agencies to compete with other agencies for funding. The ODMHSAS can download claims weekly to see how the funds are flowing throughout the system.

Washington

Linking Administrative Data Systems to Evaluate Substance Use Disorder Services

For over a decade, the Washington Integrated Client Database (ICDB) has produced a series of evaluation reports that have demonstrated the positive outcomes of the state's substance use disorder programs as well as other health and human services. These reports inform legislators and providers in their programmatic decisions.

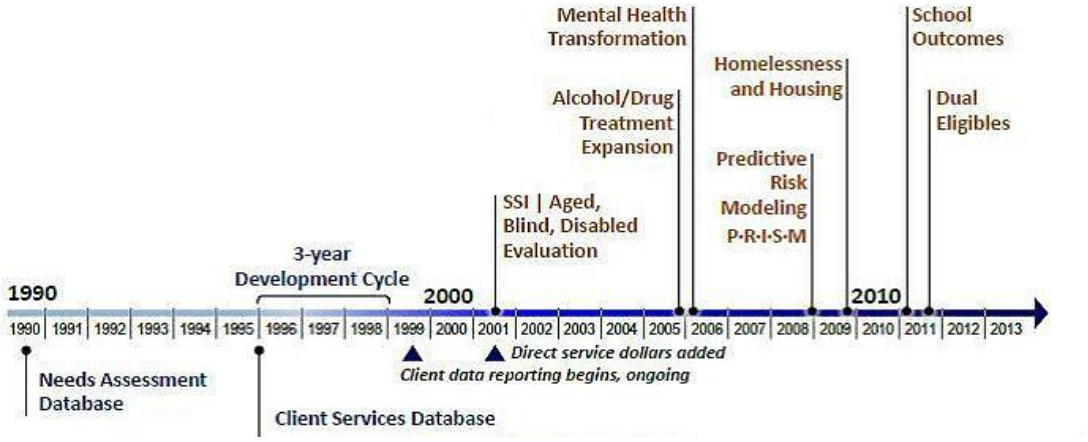
The database, developed by the Washington Department of Social and Health Services (DSHS), currently combines data from over 30 state administrative datasets. It has information on about 2.4 million individuals who have received social services, and the data span up to 20 years. Washington is one of few states with an integrated social service database; several others are Illinois, Oklahoma, and South Carolina. The ICDB is particularly renowned for its level of depth, detail, and sophistication.

Population, Needs, and Agency Collaboration

In the mid-1990s, Washington's Division of Behavioral Health and Recovery (DBHR), led by Kenneth Stark, was asked to demonstrate the effectiveness and efficiency of spending on treatment services for people with substance use disorders. The best way was to demonstrate that treatment services provided by the DBHR had significant, cost-effective outcomes.

Because the DBHR lacked strong data to make this case, it began to collect the necessary data. The department realized that by linking its administrative datasets with others it would gain a broader perspective of its clients and the impacts of state services. After many years of development, the database integrates client information, services utilization, and geographical information from 16 different agencies (see timeline in Figure B-1).

Figure B-1. Timeline for Development of the Washington Integrated Client Database



Source: Becker-Green, J. (2012). *Big data, big discoveries* (RDA Report No. 11.180). Olympia, WA: Washington State Department of Social and Health Services, Planning, Performance and Accountability. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/11/180.pdf

The ICDB was first developed as a *needs assessment database* that matched clients across multiple systems for specific services in that database. It was then transformed into a *client services database* in the latter half of the 1990s; the DSHS refined the logic used to match client information and define social services and grouped 5,000 services into 80 standard report groups. Client data reporting began in 1999 and continues to this day.

The ICDB continued to expand with additional funding and services created from the Mental Health Transformation Grant (MHTG), which the state earned in 2005. With an increased number of services, more client data were entered into the database, and additional funding allowed the ICDB to integrate with more agencies (e.g., homelessness and housing).

Creating a large, integrated database required support from multiple agencies and stakeholders. One key champion for the ICDB was ProviderOne (formerly the Social Service Payment System [SPSS]), which is the Medicaid Management Information System (MMIS) for the state. ProviderOne gives service providers a platform to manage Medicaid claims. Because the DBHR sought information on Medicaid clients, the relationship with ProviderOne was paramount to developing the ICDB. Other advocates included substance use disorder and mental health agencies that work under the DBHR and were the first to volunteer client data and integrate with the database.

As DSHS acquired more information, the state agency was able to publish a variety of reports measuring client needs and gaps in the state's social service system. These reports highlighted the value of substance use disorder programs.

Costs and Components of the Innovation

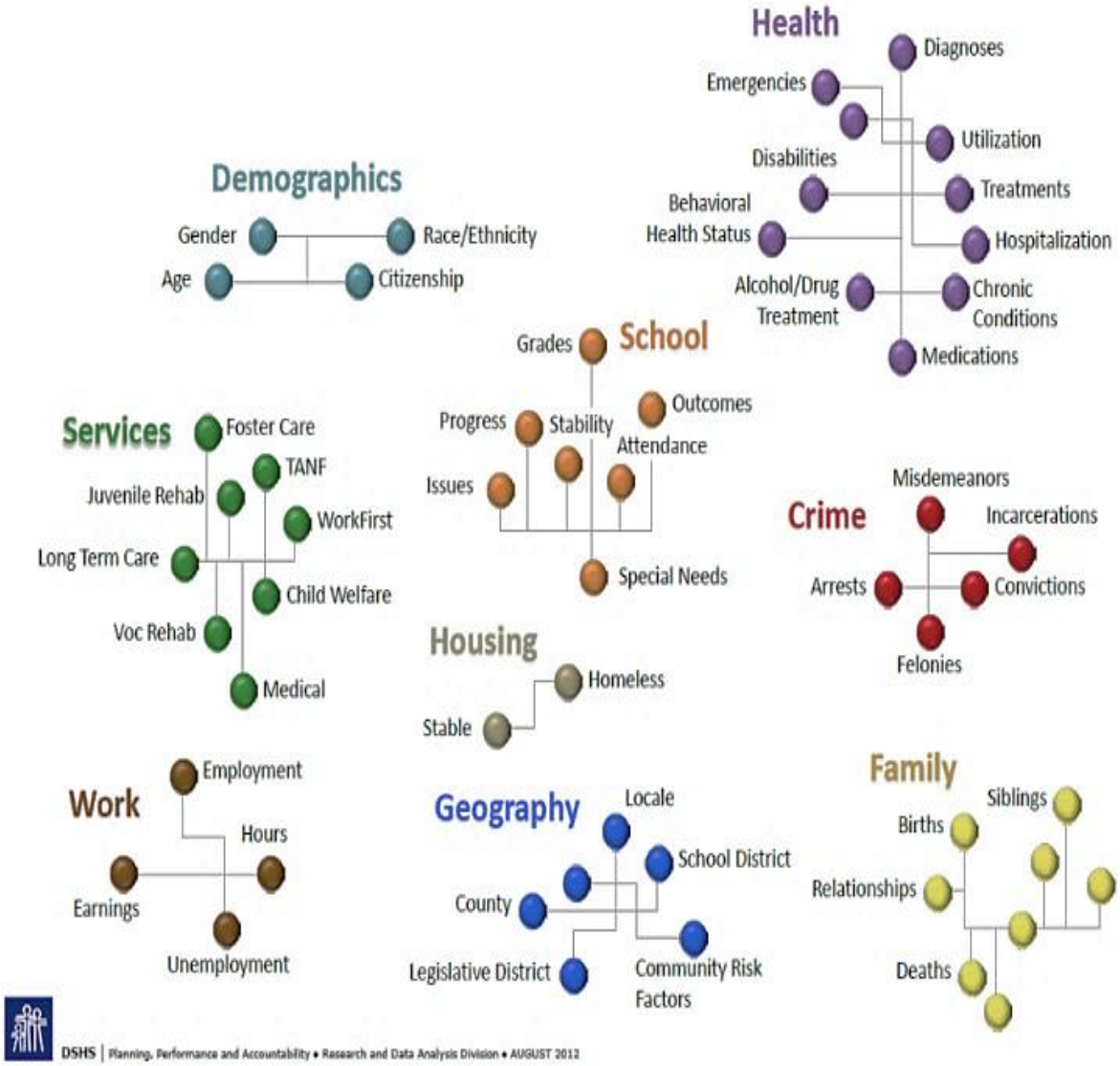
The Integrated Client Database (ICDB) contains information on 2.4 million clients. *Client* refers to any social service consumer; clients receiving substance use disorder services are only a subset of this database. The ICDB uses each client's name, date of birth, and social security number for identification. It contains data for a variety of categories such as crime (e.g., charges, incarcerations), demographics (e.g., age, citizenship), education (e.g., grades, special needs), health care (e.g., chronic conditions, emergencies), geography (e.g., county, school district), and youth services (e.g., foster care, juvenile rehabilitation) (see Figure B-2). The ICDB has information from over 30 datasets across and outside the DSHS.[55] Client information has been available for 20 years and is routinely tracked in the DBHR's intranet.

As more clients are added and datasets integrated, the DSHS combines conflicting or overlapping data to make one uniform set (Figure B-3). For example, each dataset might have different definitions for race/ethnicity or data at different location levels (e.g., city, county).

[55] Lucenko, B., Black, B., Shah, M. F., Felver, B. E., & Huber, A. (2014). *Washington court and recovery enhancement system* (RDA Report 4.90). Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/4/90.pdf

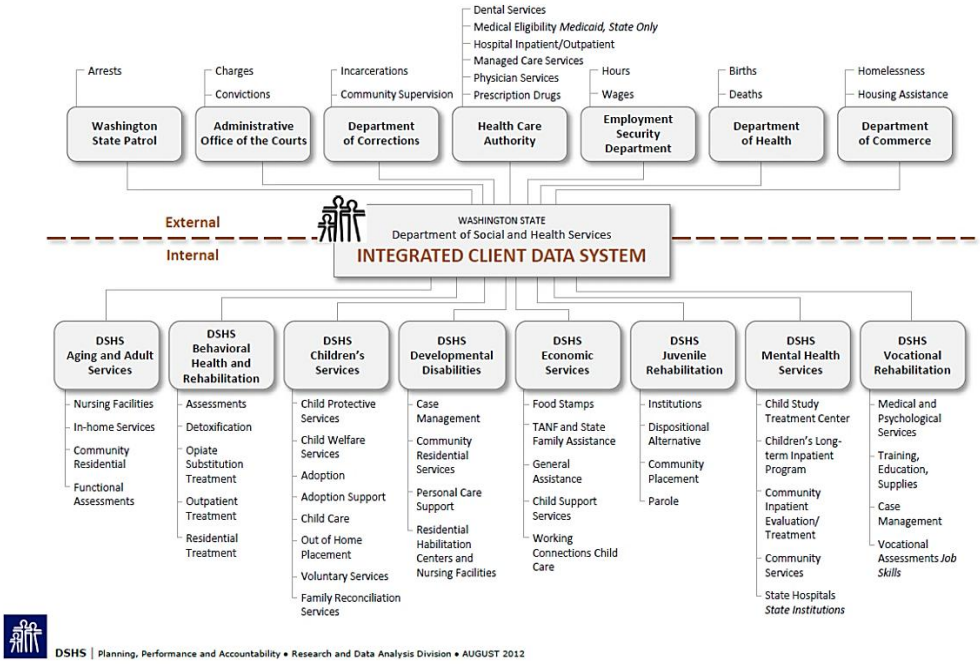
When adding clients, DSHS uses identification numbers to link information between different datasets: a computer takes a list of client IDs, searches for their information throughout each database, and links the information. The computer then returns a new research ID that is connected to the larger ICDB. To resolve conflicting data, the DBHR has developed programming (*Best Demography*) that provides best educated estimates on each variable. The data undergo this "linking procedure" routinely. The ICDB is so complex and uses data from so many agencies that DSHS needs legislative authority to make certain linkages.

Figure B-2. Data Indicators in the Washington Integrated Client Database



Source: Becker-Green, J. (2012). *Big data, big discoveries* (RDA Report No. 11.180). Olympia, WA: Washington State Department of Social and Health Services, Planning, Performance and Accountability. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/11/180.pdf

Figure B-3. Data Linkage in the Washington Integrated Client Database



Abbreviation: DSHS, State Department of Social and Health Services

Source: Becker-Green, J. (2012). *Big data, big discoveries*. (RDA Report No. 11.180). Olympia, WA: Washington State Department of Social and Health Services, Planning, Performance and Accountability. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/11/180.pdf

Most importantly, the ICDB database has a number of applications in state policy research and the provision of health and human services. This database can identify client demographics, history, needs, risks, and outcomes in multiple areas (e.g., crime, health, employment) at the state, community, family, and individual levels. DSHS researchers use the database to publish about 24 reports each year that evaluate social services, help legislators and providers make programmatic decisions, and assess clients' levels of need. Findings in the substance use disorder field, for example, include the following:

- Reductions in treatment funding associated with declines in treatment access and increases in medical and nursing facility costs for clients who are disabled and covered by Medicaid[56]
- Reductions in the risk of major cardiovascular disease as a result of treatment among clients who are disabled and covered by Medicaid[57]

[56] Mancuso, D., Norlund, D. J., & Felver, B. E. (2013). *The impact of substance abuse treatment funding reductions on health care costs for disabled Medicaid adults in Washington State* (RDA Report 4.88). Olympia, WA: Washington State Department of Social and Health Services, Planning, Performance and Accountability. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/4/88.pdf

- Reductions in arrest and incarceration rates among clients in drug court and treatment programs[58]

To ensure that the database is secure and that it is used for valid research purposes, DSHS restricts its access. Researchers and other stakeholders must ask the DSHS Institutional Review Board (IRB) for permission to use ICDB data. Users must effectively demonstrate the following:

- An understanding of what the database contains, how it works, and how it has evolved
- Why the data are valuable to their research
- How the research is in DSHS's interest—that the research will be a useful collaboration and teach stakeholders something of value

Institutions that have used ICDB data in their research include Harvard, Brandeis, Rutgers, and other universities. The ICDB is currently maintained by the DSHS's Research and Data Analysis (RDA) Department, which provides policy-relevant analyses of state government-funded social and health services and specializes in analyzing clients who use services from multiple programs designated by DSHS.[59] It costs $2.8 million annually to maintain the ICDB and conduct basic research.

Success, Challenges, and Lessons Learned

The DSHS created an expansive, sophisticated, user-friendly database that directly informs policy researchers and social service providers. The database began as a successful effort to demonstrate the efficacy its state substance use disorder services. The DSHS's biggest challenge has been maintaining the ICDB. To finance maintenance, the DBHR needs to cultivate internal funding, federal grant funding, and private foundation funding. Maintenance costs include monitoring changes in social service programs and information technology, which are always evolving, as well as attracting and retaining talented staff to perform maintenance work and research. Another challenge has been convincing other agencies to share data. The DBHR has had to demonstrate the value of integrated data and how it mutually benefits other agencies, which often demands extensive negotiation and (as mentioned earlier) legislative authority.

For states or stakeholders looking to develop an integrated database, DSHS recommends having a champion in both the legislature and higher rungs of their agencies (e.g., at the secretary level

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[57] Mayfield, J., Estee, S., Black, C., & Felver, B. E. (2013). *Drug court outcomes* (RDA Report 4.89). Olympia, WA: Washington State Department of Social and Health Services, Planning, Performance and Accountability. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/4/89.pdf

[58] Mancuso, D., Shah, M. F., Huber, A., & Felver, B. (2011). *The health impact of substance abuse: Accelerating disease progression and death* (RDA Report 4.85). Olympia, WA: Washington State Department of Social and Health Services, Planning, Performance and Accountability. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/4/85.pdf

[59] Washington State Department of Social and Health Services. *RDA's mission*. Last modified April 30, 2010. Retrieved from http://www.dshs.wa.gov/rda/mission.shtm

or a division manager) to advocate for the research needed to collect data. Equally important is being aware of and building relationships with the agency's network, especially if other stakeholders have similar questions and concerns. This helps make a case to develop an integrated database. In Washington's case, the DBHR, for example, was an umbrella agency over 8–10 other agencies, including those that handled substance use disorder, mental health, and Medicaid services. The DSHS's RDA Department also demonstrated that other agencies could share and use data without compromising it. As DBHR staff noted, this could not have been done without building relationships.

To begin collecting data, the DSHS recommends starting small with a narrow, targeted research question. Because research is expensive and time-consuming, working on a specific project minimizes research costs and helps build a case to secure funding. The DBHR staff recommends that criminal justice, education and housing, employment, and Medicaid should be the first areas to be integrated because they usually involve multiple agencies that can offer large datasets. Criminal justice data in particular can offer significant cost implications for the health and human services that are provided. Finally, DBHR stresses the credibility of an agency's data. In the same way that the DBHR developed a protocol to add and link client data between multiple databases, agencies must create a way to ensure that their data are accurate, consistent, and properly integrated. This process must occur for the sake of research and also to respect clients' history and protect their anonymity. These steps ensure that the data can be trusted and build confidence in an agency's research for policymakers and others.

Appendix C: Case Studies of Health and Behavioral Health Integration

Arizona

Background on Integration

In the mid-2000s, Arizona began assessing integration of behavioral health and physical health (also referred to as acute care) to address health concerns and improve health care outcomes. Arizona used the 2006 National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council report titled *Morbidity and Mortality in People With Serious Mental Illness*[60] as a foundational piece in assessing its system to determine needed improvements. The behavioral health community was a high driver of costs and services in the state, and identifying ways to address these high costs was a key concern.

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency. The AHCCCS supported the integration initiative and wrote the waiver for the Division of Behavioral Health Services (DBHS). Arizona only saw limited pushback from the behavioral health community on their efforts for care coordination, and that was mostly early in the process. The concern was that integration required some behavioral health organizations to change their focus from behavioral health only to both behavioral health and acute care. The integration effort began first with the Maricopa County Managed Care Organization (MCO), also known as the Regional Behavioral Health Authority (RBHA). By October 1, 2015, all other counties in greater Arizona will require the same level of integration as Maricopa County.

Financing Integration Services

On April 1, 2014, Arizona initiated a $1 billion contract to provide integrated managed health care within the state's largest county. Arizona state funds are also used to contract with MCOs at the state level. As part of the contracted agreement, MCOs receive an administrative margin as well as a defined profit or loss margin.

Each organization can bill at the rate previously approved by the DBHS. Arizona tries to align the fee-for-service rate with the MCO rate, when feasible. Consumers who are dually eligible for Medicaid and Medicare are required to be covered by MCOs. Arizona did not set up the state's Healthcare Marketplace Exchange; rather, they deferred to the federal government. The Arizona DBHS receives $100 million per year in state general funds to provide additional

[60] Parks, J., Svendsen, D., Singer, P., & Foti, M. E. (Eds); Mauer, B. (Writer). (2006). *Morbidity and mortality in people with serious mental illness*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

coverage for services for individuals who do not have insurance or to pay for care not covered by insurance.

Role of SAMHSA Block Grants

SAMHSA's Mental Health and Substance Abuse Prevention and Treatment Block Grants are incorporated into the MCO contracts. Arizona is able to analyze behavioral health services by client eligibility and funding source. Arizona uses grant funds to contract with smaller entities or for unique services. Current contracts allow for proper tracking and dispersing of block grant funds.

State-Supported Integration Initiatives

In Arizona, care coordination is a key element of integrated managed care. There are four types of care coordination in Arizona: (1) behavioral health homes; (2) primary care (physical) health homes; (3) virtual health homes, where the care is coordinated through the MCO; and (4) completely integrated health homes, with behavioral and physical health co-located under one facility. Administrators review data points that come in at any provider level and from any system, and they analyze all actions from behavioral, clinical, and support services levels. These data allow case managers to facilitate care coordination.

A large majority of providers, serving 80 percent to 90 percent of consumers in Arizona, have electronic health records and can share meaningful use information. MCOs then share the data under meaningful use rules. By 2015, there will be 20 integrated facilities with behavioral health clinics brought into physical health provider locations through contracts. Arizona officials know that once this integration is complete, this new model will ultimately allow more of a one-stop integrated care approach for clients.

Special Populations

Arizona focuses on services for adults with serious mental illness (SMI). There are some carve-out and carve-in special populations, including older adults. Nursing home care is under a fully integrated contract, meaning that behavioral and physical health care are provided at facilities for clients. For children, residential level of care is under a fully integrated contract. The DBHS has always integrated behavioral health and substance use disorder services, which allows easier integration of systems.

Arizona also has a focus on individuals with behavioral health conditions in correctional settings. Nationwide, Medicaid is often discontinued when a member goes to jail. In Arizona, Medicaid eligibility is suspended for inmates, which allows for easier re-enrollment upon release. Arizona is currently working with Medicaid to coordinate care and maximize coverage options for incarcerated populations.

Another focus area for Arizona is tribal populations. Arizona has intergovernmental agreements to allow tribal populations to access services. Through these agreements, individuals have the

choice of access through a variety of service venues, such as tribal services, Medicaid, and MCOs.

Role of Health Information Technology in Supporting Integration

Once Arizona's Health Information Exchange (HIE) is operational, care coordination will be tracked and managed more easily through the HIE to support all provider members. Providers will give detailed information including claims data and patient data to the HIE. The HIE system will allow providers to review the services rendered across behavioral and physical health. MCOs will have the responsibility to review and provide data, while the state has authority to audit MCOs. The systems will use policy measures, network, and care management standards to review the level of quality care and integration.

The Arizona State Hospital (ASH) has its own EHR, based on the NetSmart avatar system. The ASH is currently updating the system and will meet meaningful use Stages 1 and 2. Clinical data are shared between the hospital and MCOs.

Measurement of Outcomes of Integration

In addition to analyzing their internal measures, Arizona uses an independent organization to review effectiveness. They review levels of need for Supported Housing, Supported Employment, access to consumer-operated services, and utilization of Assertive Community Treatment. This process includes Maricopa County, where the MCO is responsible for measuring outcomes such as utilization rates, access to care, and readmission rates.

Barriers to Integration

A key barrier in Arizona continues to be workforce issues. There is recognition that the workforce needs to grow and meet the variety of training requirements included in state contracts with MCOs. Arizona MCOs will conduct most of the training, and Arizona has financial incentives for professional training, particularly to work in rural areas. Another barrier is finding enough funds for IT infrastructure for behavioral health, because lack of funds hampers the forward progress of the initiative.

Additionally, the federal substance use disorder confidentiality law 42 CFR creates challenges. Arizona's experience is that 42 CFR restricts their ability to share information to coordinate care for individuals with substance use disorders. Arizona considers this law to be outdated, as perceptions of substance use disorders have changed with time—there is less stigma and resistance to receiving substance use disorder treatment. Statute 42 CFR is now a hindrance to whole-person treatment, and it needs to be modified.

Lessons Learned

Arizona officials know that part of successful integration is the expectation for all providers to integrate services. Community providers that choose to integrate services are given incentives to participate. If providers do not choose to integrate services, Arizona then allows providers to opt

out and remain as behavioral health service providers only; the MCOs are then responsible for coordinating care. Providers can still be singular focused, but MCOs will integrate data to coordinate the care. There are several behavioral health clinics in the state that are being integrated, and other facilities have found that integration through co-location provides a model that is easy to understand and implement.

Arizona found that the services they provide are considerably different from those in fee-for-service states. Arizona has moved away from being only a behavioral health authority. As a result, it is moving away from the "one off" service approach and toward a more systemic, holistic approach. Arizona has devoted extensive time and resources to build a user-friendly website and to maximize the development of social media platforms that clients can access. These products have informed consumers and families and supported their systems change efforts. Finally, updating Arizona's staffing competencies and training to react to contractual requirements, fiscal monitoring, and a holistic system approach are keys to success.

District of Columbia

Background

In the District of Columbia, the genesis of the integration efforts came through the realization at the Department of Behavioral Health (DBH) that too many early deaths (before the age of 50) were occurring among state mental health agency (SMHA) consumers. The DBH wanted to understand what was happening to consumers and take steps to improve their overall health status. The DBH expects planning of major activities for health and behavioral health integration to continue through January 1, 2015. Although there is still much to be accomplished, the DBH is issued for public comment a proposed Medicaid State Plan Amendment to create health homes in June 2014. There are seven federally qualified health centers (FQHCs) in the District of Columbia.

Financing Integration Services

The District of Columbia will use Medicaid paid services and will submit a State Plan Amendment in order to be eligible for a 90 percent match for funds that Medicaid has made available for state agencies. In addition, this match of funds will allow the District to bundle services.

Anticipated State-Supported Integration Initiatives

The District of Columbia is currently engaged in an extensive, 3-year planning process, which will culminate with the implementation of state-supported integrated care management activities. As part of this 3-year planning process, the District conducted quality reviews of providers for a select number of clients with behavioral health conditions. All quality reviewers were employed by the District.

The reviewers went into the field to survey and determine the level of performance and quality of primary mental health care coordination. In particular, reviewers checked to see if the client under review was linked to an existing primary care provider. If there appeared to be a link, the reviewers determined whether there was active communication between behavioral health and physical health providers in the care of that client. The reviewers then were able to look at these cases to review performance and level of integration. Reviewers examined several hundred cases and ultimately discovered that the level of behavioral health client contact with primary care providers was higher than anticipated.

The District of Columbia DBH will implement a comprehensive screening tool to review mental health needs, substance use disorder treatment needs, physical health care needs, residential support, social support services (including housing, employment, and other social supports), corrections, etc. The screening tool will be required upon intake. Providers will receive an increased rate for completing the assessment, which will be used to inform an individualized rehabilitation plan.

Health Homes

Health homes in the District of Columbia are part of an overall State Plan Amendment application published for public comment June 2014. The health homes will focus primarily on recipients of Supplemental Security Income (SSI) and individuals with serious mental illness (SMI). The DBH anticipates that health home programs will commence in 2015.

Improvement of health outcomes is the driving force in the move to implement health homes. The DBH estimates that about 16,000 adults with SMI will be eligible for health home services (out of an estimated total of 20,000 adults with SMI). The estimated 16,000 individuals eligible for health home services primarily will be individuals who are currently covered by Medicaid under fee-for-service payments. Based on the DBH's analysis of consumers, it is estimated that 42 percent of enrollees will have a co-occurring physical health condition. The DBH expects that there will be some newly eligible clients, but most clients will be from the District's currently eligible population of individuals with SMI. The DBH expects that the majority of community behavioral health providers will serve as health homes.

The District has recognized that staff recruitment will play a major role in the success of health homes. Finding and recruiting talented staff to work with providers are high priorities for the DBH. The DBH is currently reaching out to physical health care providers to develop a recruitment plan, and they will continue this outreach over the next few months. In an attempt to help bolster the recruitment plan, the DBH is looking at the model for care coordination that states such as Missouri have used for their health homes. At present, the largest staffing concern will be whether mental health providers will be able to hire sufficient numbers of registered nurses and other physical health care staff.

The DBH is also working to complete a staffing model that will be able to help with a number of calculations and will detail staffing needs by discipline. Within the model, the DBH has also defined roles and responsibilities for each health home staff position. In the model, the DBH has identified staff member time allocation down to the minutes spent per client. For example, nurse practitioners spend an average of 8 minutes of care per person per month. This allows the DBH to make adjustments and projections on the cost of staffing. The District's model also indicated a projected dollar amount needed for billing to make the staffing model sustainable and effective. The DBH worked closely with Health Management Associates (HMA) as a consultant to develop this hourly, per staff member cost detail.

Role of Health Information Technology (IT)

Health IT is a large supporting function within the initiative to integrate care in the District of Columbia. Although the District is still in the planning phase, the DBH has decided that it will use a single system that will interface with all other systems to perform analyses. The system, called Integrated Care Applications Management System (iCAMS) is being developed by Credible Wireless Systems and went live in September 2014. When it is fully operational, the

system will use information from electronic health records (EHRs) and Medicaid claims data. iCAMS will have the ability to share information about diagnoses and medications to approved users within the system. In addition, it will be capable of direct messages to users, allowing more integrated communications between users across behavioral and physical health fields. Any provider will be able to submit information for a medical record and can pull information on both behavioral health and physical health care from a client's record. iCAMS is also designed for outcome monitoring. Outcomes tracked via the system will include the following:

- Smoking cessation
- Length of stay
- Hospitalization by diagnosis
- Reason(s) for admission

iCAMS will be a mandated system for all public behavioral health providers in the District of Columbia. The system will be built to comply with mandated HL7 transfer rules for EHRs. When implemented, security will be a top priority for the system, and there will be real-time interface for users through a firewall. At present, there will be no anticipated implementation costs for providers except for training additional staff. The DBH will have general training sessions.

It is anticipated that St. Elizabeth's Hospital, which is the public psychiatric hospital, will continue to use the avatar system for the time being, but they are hoping that eventually the hospital will migrate to iCAMS. There will be a real-time interface in iCAMS with avatar.

Other Integration Efforts

The District of Columbia Behavioral Health Quality Initiative was started for connectedness of basic health information for clients. It aims to ensure that systems such as iCAMS will allow providers to work in concert to use integrated behavioral health information.

In 2013, the District of Columbia integrated the mental and substance use disorder agencies into a single state entity. The goal is for these two former District entities to collaborate to develop a set of criteria by the end of 2015 that will assess each patient for mental and substance use disorders regardless of provider. The District of Columbia is looking to implement a comprehensive screening tool that will capture this information and can be levied as part of payment.

In addition, the District of Columbia has been working on pediatric screening for behavioral health needs. In fiscal year 2015, the District of Columbia will fund a $500,000 per year initiative targeting 500 pediatricians to screen for mental and substance use disorders. The District of Columbia Medicaid and the DBH are working in close collaboration with Children's Hospital Georgetown and Managed Care Organizations (MCOs) on this pediatric behavioral health screening.

Impact of the Affordable Care Act

The District of Columbia has already realized some of the savings from the newly expanded Medicaid because the District's behavioral health agency now has a decreased non-Medicaid caseload. The DBH estimates that there are about 4,000 newly eligible individuals with behavioral health issues. The DBH's distribution of individuals who are not covered by Medicaid has decreased from about 30 percent to about 7 percent.

Barriers to Integration

Despite efforts to recruit qualified candidates, the DBH found that the lack of workforce may be their biggest challenge to integration. This staffing barrier represents a lack of available qualified workforce to staff health homes. To integrate behavioral health and physical health successfully in the health home environment, the DBH anticipates needing an additional 80 physical health care staff members. Another issue was getting the providers to see the benefits of care coordination and hiring nurses and others to provide integrated care.

Lessons Learned

The District of Columbia found that a key facilitating factor to integration has been a very positive relationship with the District's Medicaid Agency and shared interest with Medicaid on improvements in care and cost-saving measures. The DBH found that engagement of providers and public service agencies early on and throughout the process was crucial. It was also essential to have good information technology support and leadership within the staff to address needs (e.g., Medicaid, finance, IT). The District found that two factors facilitated rapid progress on health homes: (1) collaboration with other states on training and (2) a strong and positive working relationship with the District's Medicaid Agency.

Including providers in planning for changes involving health IT is a benefit. In the initial introduction of the Credible Health IT system, providers were resistant to using a single Health Information Exchange. As implementation has progressed, the benefits of the system assuaged concerns from providers. The back-end linkage to other systems raised the level of interest from providers. In addition, designing a system that can be used on mobile apps (e.g., can operate on an Apple iOS) raised interest from providers.

Maryland

Background

Maryland has two initiatives to integrate behavioral health and physical health care: health homes and Behavioral Health Integration in Pediatric Primary Care (B-HIPP). There are 57 health homes approved under the Chronic Health Home Option and 16 federally qualified health centers (FQHCs) in Maryland. There is co-location of services at the FQHCs.

Financing Integration Services

Maryland has received $1.5 million from a number of private foundations to set up Way Station's pilot programs covering 800 individuals. Using these funds, the Department of Health and Mental Hygiene (DHMH) was able to prepare and test the programs before full implementation. State general funds have been used for the B-HIPP program. In addition, Maryland has used the U.S. Department of Education Race to the Top grant.

Medicaid funding has also played a role as services are paid through Medicaid. Maryland has adopted a flat rate model for provider billing, because it has an easier tracking method for providers and a simpler reimbursement process. Moreover, to allow more flexibility to providers, Maryland allows them to begin billing the state once core staff members are in place but before provider teams are fully staffed. The eligibility criterion only applies to high-level behavioral health services such as Assertive Community Treatment (ACT), psychiatric rehabilitation programs, or opiates.

The B-HIPP programs have been funded primarily with state dollars, but some funding has come through federal dollars from the Psychiatric Residential Treatment grant and the Race to the Top grant. The DHMH is trying to prevent later higher service needs. They will use Medicaid savings to fund this initiative. Medicaid savings mean that they expect state general fund savings to result from some of their projects, and they will use those funds as a funding source for a children's program.

State-Supported Integration Initiatives

There are two overall goals for the health homes: improve health outcomes and decrease health costs. To achieve these goals, the DHMH has identified major elements needed for health home implementation for behavioral health. These elements include the following:

- Evidence-based practices (EBPs) for consumer participation
- A health homes practice model; Maryland currently uses the Integrated Illness Management and Recovery (IMR) model, but this is a specialist model and a more generalist model is needed for health homes
- A culture shift for providers from being reactive to crises to a focus on population health
- Disease management approaches for managed care organizations (MCOs)

- A shift from a linkage model to care management.

Each health home has three primary components, as described below.

- **Care Management Approach**. Health homes are hiring nurse care managers and ACT teams to become physical health care managers. In the care management approach, health homes are creating a working relationship for the client that integrates physical health care and behavioral health care. Health homes hire nurse care managers to work with the psychosocial treatment team.
- **Co-location**. In Maryland, approximately 20 percent of health homes are currently co-locating behavioral health and physical health care services at facilities or satellite sites. Although co-location seems to be spreading across the state, there are some concerns around this model of care. One highlighted concern that must be addressed is that the staff members at co-located facilities have difficulty adjusting to differentiated dimensions of care. The mental health needs of clients can be deprioritized in favor of urgent physical needs. The IMR model is an important component of that prioritization.
- **Increasing Client Participation in the Care**. In Maryland, clients are encouraged to feel more empowered by participating in their care. The Maryland DHMH has integrated illness management and recovery services at health homes to facilitate increased client participation. It is believed that by integrating services clients can more easily manage and comprehend differentiated components of their total care. Moreover, health homes are using an integrated IMR model to increase the client's participation in coordinated care.

In addition to the health homes, pediatric and adolescent care programs are a priority for health and behavioral health integration in the state. The B-HIPP initiative is a key programming element to overall integration efforts. The B-HIPP program aims to shift the focus from physical health care only to an integrated approach while also providing more effective behavioral health care. The B-HIPP program covers early childhood to transitional age care. The program recognizes the high degree of comorbidity among the children and adolescents they serve. It has been active statewide for less than 1 year, but has been in operation for a longer period.

The B-HIPP program has enrolled approximately 250 providers, which include roughly half of the practicing pediatricians in the state. This coverage of providers represents roughly 1,000 direct patient contacts between the providers and the social workers. In Maryland, the providers have a high degree of penetration in rural areas, particularly in western counties and the lower Eastern Shore of Maryland.

B-HIPP Outreach and Training Programs

The B-HIPP outreach program includes a telephone line for clients to call directly, which is known as a *warm-line service program* component. The warm-line service provides behavioral

health and developmental disabilities consultation directly to clients who call. As a commitment to client service, the warm-line service program has one full-time employee dedicated to maintaining a list of referral resources for clients who call the service center. This call center is also staffed with two highly experienced child psychiatrists and three social workers with master's degrees.

The B-HIPP program has a structured training program for social workers who want to be co-located with physical health care providers in the state. (The training program is currently limited to the lower Eastern Shore of Maryland, but is expected to expand over time.) The B-HIPP program also partners with Salisbury University on the development of a social work co-location model. This model is particularly useful because many social workers in the B-HIPP program are co-located at sites. These social workers include student interns who work with pediatric primary care practices. The focus of this model is primarily on placements in rural areas. At present, the B-HIPP social worker program has graduated one class of 70 social worker interns. Next year, the program will expand to Carroll County, where they will fund two slots for intern's classes. The program also has a substantial evaluation component that will provide B-HIPP staff members with feedback to help improve the training program.

Maryland has alternative models for service training in addition to the B-HIPP training model. One such training is a School Provider Program, for which the Maryland state mental health agency (SMHA) provides school nurses on site to expand the service offerings for children and adolescents. In addition, some providers have implemented their own training for social workers based on SMHA models, and they have built the cost of this training into provider overhead budgets. To date, the B-HIPP program has completed about 80 outreach and training events across the state.

Health Information Technology

Maryland has a Health Information Exchange (HIE) to track client data. The HIE does not exchange clinical information between users and providers; however, it does provide alerts to providers for emergency room and hospital admissions, which allows limited integration of client data. In practice, this manifests as behavioral health providers receiving an automatic e-mail alert whenever an individual in care is hospitalized.

Maryland's HIE provides a dashboard and outcome measures that allow them to perform population health management analyses. The system uses Medicaid paid claims data. Maryland is introducing data analytics through this system at the community-care level. The state is using the tool to manage care costs. There are now 30–40 sites located in the 14 largest providers in Maryland that are using the data tool.

In addition to the HIE, Maryland's SMHA has implemented a data tracking system to measure the performance of the B-HIPP program's warm-line call center for clients with behavioral health

conditions. Maryland's B-HIPP data collection system tracks every call made to the warm-line service and collects clinical data on clients. The system allows administrators to determine how many clients have been served, who called a facility, and the subject of the client's call. Workers on the telephone line screen every call to make sure they are providing consistent information. In the next year, the DHMH anticipates working with providers who are already tracking services offered to use these systems as a model to expand the data system's capabilities. These expanded capabilities would include tracking clinical outcomes data in the future.

Measurement of Outcomes of Integration

To support health homes, Maryland adopts a Care Management tool that was developed by the state of Missouri. Maryland providers purchase this tool directly for use on outcome measurement. To offset the cost of providers using the tool, the DHMH is reimbursing providers for its use and implementation.

Barriers to Integration

Maryland has found that lack of access to quality care is a major barrier to integration of physical and behavioral health services. In addition, as mentioned above in the three components of health homes, another key barrier across the state is the lack of active client engagement in coordinated care. With regard to staffing, another barrier is difficulty with licensing of social workers after completion of training programs and placement within facilities. This barrier affects funding to the state and the integration of social workers into provider service offerings. Despite the B-HIPP program's success, Maryland had found that program funding was a barrier. For Maryland to support the B-HIPP program, the SMHA found that it needed to piece funding from multiple resources. More flexibility in funding could have alleviated this problem. Finally, Maryland noted that there needed to be a culture shift from reactive to proactive care among its providers.

Lessons Learned

Maryland has found that the B-HIPP program has been an overall success, and the SMHA believes that the B-HIPP concept can be expanded to other age groups. As a commitment to this expansion, the SMHA has extended the B-HIPP warm-line service coverage. Originally, the warm-line program was intended to service calls only from underserved regions of the state; now, it has been implemented statewide. The B-HIPP program also includes a very detailed database of community mental health resources for children (e.g., services covered, waiting lists).

Maryland found that culture change is important for both behavioral health care and physical health care. A robust offering of comprehensive programs to make implementation more palatable to providers is important. Active knowledge transfer and technical assistance were keys to success. Maryland found that another key lesson was identifying early adaptors of the new system and using these adaptors as champions for change. Having flexible funding and being able to combine funding from multiple sources were significant aspects of success. Finally, nurse care managers were needed to perform interventions.

Michigan

Background

The state of Michigan is thoroughly engaged in health and behavioral health integration activities through streamlining policy activities, improving data analysis, creating pilot and demonstration projects, and developing Health Information Exchanges (HIEs). The leadership within the Department of Community Health (DCH) is committed to integration. Through this commitment, Michigan is well underway to achieving a whole-health approach to integration.

The DCH oversees the Behavioral Health and Development Disabilities Administration, which includes the Bureau of Substance Abuse and Addiction Services. Additionally, the Medical Services Administration is within the DCH, and it has primary oversight of the Medicaid program and Public Health. Through this organizational structure, Michigan has been successful in building collaborative leadership teams who are working toward full integration. Information about the specific integration initiatives achieved or underway is outlined on the DCH website.[61]

Michigan is a Medicaid expansion state that has received national acclaim for its expansion plan, titled *Healthy Michigan Plan*.[62] Michigan was recognized for its unique approach to expansion in an article published recently in the *New England Journal of Medicine*.[63] Additionally, the state has prepared a State Plan Amendment to establish behavioral health homes with the launch expected by July 2014. Michigan also has a robust Health Information Exchange effort underway, which includes behavioral health providers. The state is a Dual Eligible Demonstration grantee from CMS. This demonstration is building on the two existing managed care systems: specialty behavioral health through the Prepaid Inpatient Health Plans (PIHPs) and the physical health managed care system through the Medicaid health plans.

Michigan has 10 PIHPs. A PIHP is a federally designated entity under the Social Security Act managed care section. The PIHPs in Michigan are entities created by the community mental health centers (CMHCs) in a particular region. The regional PIHPs are separate legal entities, but they have appointees representing the CMHC regions. The PIHP, which accepts Medicaid as the managed care entity, is very closely linked to the CMHCs, which have responsibility for delivery of the safety net behavioral health services in Michigan. The PIHPs are offered "right of opportunity" to manage Medicaid specialty services through application at each point of waiver renewal. Should the PIHP not provide an acceptable application, the region would be opened to competitive bid inclusive of private entities.

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[61] Michigan Department of Community Health. Website. http://www.michigan.gov/mdch/0,4612,7-132-2941_58005-251689--,00.html

[62] Healthy Michigan Plan. Website. http://www.michigan.gov/healthymiplan

[63] Ayanian, J. Z. (2013). Michigan's approach to Medicaid Expansion and Reform. *New England Journal of Medicine, 369*, 1771–1775.

A separate legal-entity board governs the PIHP. The PIHP board has representatives appointed by the CMHCs. Although a separate board governs the PIHP, each CMHC has a stake in the PIHP. Michigan has 46 CMHCs, including federally qualified health centers (FQHCs) and rural clinics, which vary in co-location of services. For the first time in 2014, the quality strategy for Medicaid allows at least half of the PIHPs to choose and monitor a Healthcare Effectiveness Data and Information Set (HEDIS) measure related to physical health status in addition to the behavioral health quality monitoring. The key to the Michigan system is keeping financial and quality incentives balanced across managing entities and funding streams such as Medicaid and state general funds.

Integration Initiatives

A central player in the behavioral health and health integration efforts is the Michigan Learning Community.[64] The Learning Community is a collaborative effort between the Department of Community Health, The Michigan Association of Community Health Boards, and the National Council for Behavioral Health. There are 24 learning communities in the state. These learning communities provide an avenue for organizing conversations, planning, training, and sharing of resources from the different models within the states. These learning communities have co-located services that use a mixture of approaches, such as physical health care integrated within a behavioral health setting and behavioral health integrated in a physical health care setting. Many of these learning communities are located with or part of FQHCs.

The Michigan Primary Care Association website[65] provides information about Michigan's primary health care and behavioral health integration efforts. The website describes efforts between FQHCs and rural health clinics and behavioral health, inclusive of many CMHCs (see interactive map with explanation of degree and detail of integration models on the website).

Some noted integration initiatives are as follows:

- Michigan is integrating substance use disorder managing entities called Coordinating Agencies and the PIHPS, which are Medicaid specialty behavioral health managers. This integration of the entities that manage mental health funding streams with those that manage substance use disorder funding streams is the first step toward better physical health care integration.
- *Healthy Michigan Plan* has a close linkage between physical health, behavioral health, and public health and is inclusive of recovery models for patients.
- Demonstrations for individuals who are dually eligible for Medicare and Medicaid are being piloted in four regions. Michigan has chosen the managed care plans that will be

[64] Practice Improvement Steering Committee. (October 11, 2012). *Meeting summary*. Retrieved from http://www.michigan.gov/documents/mdch/10-11-12_Minutes_426158_7.pdf

[65] Michigan Primary Care Association. Website. www.mpca.net

participating, has a Memorandum of Understanding signed with CMS, and is currently in the readiness review process. This readiness process includes determination of readiness of the public mental health system, which is playing a lead role in managing Medicaid specialty behavioral health services and newly managing Medicare behavioral health.

Health Homes and Specialty Populations

Michigan has undertaken significant policy reviews and changes to better align and promote integration efforts throughout the state. Michigan became a Medicaid expansion state in April 2014 and a managed care state with a carved out behavioral health benefit. Michigan's leadership is reviewing the Medicaid policies to ensure consistent policies across the state systems, such as billable physical health care and behavioral co-located services. Additionally, new assessment tools are being developed and implemented statewide to better assess integration activities.

There are pilot projects underway related to the establishment of behavioral health homes. There will be three or four programs with co-located sites; behavioral health will be co-located at a physical health provider or physical health will be co-located at a behavioral health provider. Assertive Community Treatment (ACT) will also be provided in these pilot behavioral health homes. Cost savings of health homes will be measured by the pilot homes as well as the Michigan Health Link, which is part of the Dual Eligible Demonstration project. Michigan has specified eight top comorbid conditions to be measured in the health home pilot.

Michigan has a U.S. Department of Veterans Affairs (VA) initiative. They are implementing a "No Wrong Door Strategy" with several pilot programs. Partnerships continue to evolve between CMHCs, FQHCs, and VA clinics toward more effective and timely hand-offs between systems when appropriate. Some telemedicine programs are also working with the VA; the VA provides the psychiatrist and the CMHC provides onsite support to the client.

Data and Monitoring

Michigan has a robust data warehouse. The database includes claims data for Medicaid and comparable or parallel encounter data for non-Medicaid, publically funded services. These include federal block grant, state, and locally funded services for substance use disorders and mental health as well as services for individuals with developmental disabilities.

Michigan has developed two key projects that use data from this warehouse to further population-based health and integration. Those two projects are (1) Care Connect 360, which is used to inform care, and (2) Data Extracts, which are used to analyze population-level data across physical Medicaid managed care and Medicaid specialty behavioral health care through CMHCs. Care Connect 360 and the Data Extract project both pull data directly from the data warehouse containing Medicaid and non-Medicaid claims and encounter-level data (block grant data, housing authority data, and human services data). Michigan has developed a Data Use and

Confidentiality Agreement that allows for the sharing of Medicaid and mental health claims, encounter, and beneficiary data from the DCH data warehouse (copies of this agreement are available through the Department by contacting the State Mental Health Association). Clinical health record information that is not included in the data warehouse or available through Care Connect 360 or the Data Extracts process is available in an electronic health record (EHR). Even though the clinical data are in the state data warehouse, all 46 of the CMHCs in Michigan use EHRs in their systems of care.

Michigan's HIE provides real-time clinical information between the public and private health care system's providers. There are six sub-state networks that are exchanging information for locally determined "use cases" of importance to those localities and providers. CMHCs are being welcomed into these exchanges by leaders in Medicaid, the Governor's Health Information Technology Committee, and the Michigan Health Information Exchange (MiHIN). General information about the Michigan Health Information Exchange efforts can be found on their website.[66] MiHIN has a Microsoft® PowerPoint presentation that provides a useful overview of how the Exchange was created, how data can be shared, types of cases, and how behavioral health information is shared. The presentation may be requested through the contact information on the website.

Although all CMHCs have EHRs, it is challenging to create standard formats for EHRs so that information can be exported and imported from and to a variety of different physical health and CMHC-based provider systems. MiHIN meaningful use cases are assisting with exchange of physical and behavioral health information such as admission discharge and transfer messages (ADTs) from hospitals to providers of all types where appropriate consent and legal agreements been established.

Key Barriers

Michigan identified the following key barriers:

- The 42 CFR Part 2 regulation makes health information exchange challenging for individuals with substance use disorders. Patient information is now available and well integrated between mental health, developmental disabilities, and physical health. Missing information such as lab results and medications related to addictions is a significant barrier to integrated care. Michigan would like to know how to handle exchange and consent for information related to substance use disorder under the restrictions of 42 CFR Part 2.
- Behavioral health providers do not receive the incentive payments for using EHRs and thus are limited in exchanging e-health information. The state data and technology leadership and the other agencies and providers recognized the need to improve

[66] Michigan Health Information Network Shared Services. Website. http://mihin.org/

behavioral health information exchange. To demonstrate the value of exchanging behavioral health information and to identify issues in the exchange of this information, Michigan began developing meaningful use cases for behavioral health and identification of other exchange and analytic efforts across systems.

- Data requirement differences between substance use disorders and mental health, Medicaid, and hospitals are a barrier. The lack of standardization independent of the funding source is a barrier. For example, there should not be two or more different data systems to support behavioral health services paid by Medicare and Medicaid funded systems versus block grants.

Lessons Learned

Support from Medicaid and collection and availability of data have been critical to Michigan's health integration progress. SMHA leadership believes their success is partly related to better communication between behavioral health leaders, Medicaid, and health information technology (HIT) leaders in Michigan. Additionally, key leaders in Medicaid, HIEs, and the Data Enterprise system for the state are committed to the concept that behavioral health is essential to health.

Key lessons learned are as follows:

- Population health language is commonly being adopted across systems (behavioral health is identified as a key part of Medicaid and public health systems).
- It is important to discuss meaningful use with HIE and HIT partners. In working with the data exchange, Michigan talks about clients, presents meaningful use case vignettes, and determines meaningful use of exchanged information. HIE and HIT leadership developed a Michigan Model for Behavioral Health Information Exchange at the request of the mental health authority, which has been extremely useful to developing integration.

Oregon

Background

The Addiction and Mental Health Services of the Oregon Health Authority (OHA) provides the access and delivery of services for both addiction and mental health treatment. In 2011, Oregon began community-based planning to move toward an integrated benefit model and coordination of care in advance of Medicaid expansion. The mental health authority and substance use disorder authority were reorganized in the preparations for integration, which merged all health-related services (Medicaid, mental health, substance use disorder, public health) into the OHA. This reorganization was done to centralize health policy and purchasing for Medicaid and the state employee health insurance plan. As a result, the OHA now covers health services for one-third of the Oregon population. With this large system, the OHA should have greater influence and leverage on overall health care in Oregon.

Financing Services

As a consolidated health purchasing authority, the OHA houses both Medicaid and behavioral health services; the health authority's Division of Medical Assistance Program is responsible for Medicaid behavioral health benefits.[67] Since 1997, the state has used a managed care model to finance the delivery of Medicaid-funded mental health services for provide almost all behavioral health services, using local managed care organizations. Medicaid-funded substance use disorder services were separate from mental health services until 2012. The Medicaid division made an active effort to include other departments in coordinated care efforts through this reorganization. The state rotated senior staff from various agencies being merged so that they could coordinate the reorganization. For example, leadership from the mental and substance use disorder authorities temporarily rotated into positions in Medicaid.

Oregon received a $45 million grant from CMS for the Transformation Center to help coordinated care organizations (CCOs) achieve better health, better care, and lower costs for the people of Oregon. The Center will support CCOs in adopting a coordinated care model and provide a forum for sharing information and best practices. More information about Oregon's Transformation Center is available on their website.[68]

The Mental Health and Substance Abuse Prevention and Treatment Block Grant funds are used by community mental health programs to enhance detoxification programs and to elevate services for offer integrated care. Oregon also uses the block grant funds to pay for services for individuals who are not eligible for Medicaid and for supports and other services that are not reimbursable by Medicaid.

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[67] National Academy for State Health Policy. *Behavioral health in the Medicaid benefit for children and adolescents: Oregon*. Website. http://www.nashp.org/behavioral-health-medicaid-benefit-children-and-adolescents/oregon

[68] Transformation Center. Website. http://transformationcenter.org/

Coordinated Care Organizations

The key element of Oregon's new service system is the development of CCOs, which are responsible for all health services for residents who receive coverage under the Oregon Health Authority. The state has 16 CCOs that form a network of providers, including physical health care, addiction, mental health, and dental care providers. The CCO systems allow flexibility in designing models that meet the needs of the target populations served. In addition to providing treatment and management of chronic diseases, CCOs must focus on disease prevention.

CCOs are organized regionally and are all locally based. There is one budget that grows at a fixed rate for mental, physical, and dental care. CCOs are held accountable for health outcomes of the population they serve. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk. The Medical Assistance Division of the Oregon Health Authority contracts with the CCOs. The state's former capitated managed care plans were all integrated into this new model. OHA is developing strategies to include in the CCO contracts that integrate Medicaid payment for adults with serious mental illness (SMI) who receive services in the community.

Each CCO must develop a transformation plan, which requires a step to ensure the integration of physical health and behavioral health care. The transformation plans have components for services for special populations. The state also consulted with the U.S. Department of Justice (DOJ) and made certain that the transformation plans supported the state's agreement with the DOJ. More information about Oregon's CCO model is available on the Oregon Health Policy Board's website.[69]

Health Homes

Patient-Centered Primary Care Health Homes (PCPCHHs) have existed in Oregon under a state law since 2005. A PCPCHH is a health clinic that is organized to provide patient-centered care principles. The patient and doctor collaborate in decision making for a course of treatment. The PCPCHH also can connect patients with specialists as needed. Oregon has developed a website devoted to providing helpful information to consumers about the state's PCPCHHs.[70] Very few of the PCHCHHs have behavioral health services embedded within the clinic. Oregon is currently working to establish behavioral health homes. A learning collaborative is assisting with the development of the physical health care capacity for specialty populations with 10 providers.

Measurement of Outcomes of Integration

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[69] State of Oregon Health Policy Board, Coordinated Care Organizations. *About health system transformation*. Website. http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx

[70] State of Oregon, Patient-Centered Primary Care Home Program. *Patient-centered primary care home program*. Website. http://www.oregon.gov/oha/pcpch/Pages/index.aspx

The CCOs have a set of outcome performance measures incorporated into each of their transformation plans. Data for the measures are submitted through Medicaid encounter claims. Each CCO's transformation plan includes a provision on performance measures called CCO Incentive Metrics. CCOs have agreed to focus on quarterly metrics to be published on a website. The Oregon Health Authority's CCO incentive metrics are used to measure how well CCOs are improving care, providing accessible care, eliminating health disparities, and reducing the cost of health care. More information about the CCO incentive metric, the parameters used, and unique details of the model is available on the Oregon Health Authority's website.[71]

In addition, Oregon is implementing a new mental health data system to capture more information from providers about the services that individuals receive. The old system did not capture detailed information on encounters. This information will allow Oregon to compare non-Medicaid paid data with Medicaid data. This will also allow Oregon to ensure that block grant funds are not used to pay for services that could be paid by Medicaid.

Lessons Learned

Integration of behavioral health and physical health care is a complex undertaking. It requires detailed planning and the exploration of many possibilities. It is very important to have the legal and statutory authority and organizational structure established in advance of making system changes to integrate physical health and behavioral health care. These features provide the foundation for change.

[71] State of Oregon, Oregon Health Authority. *Technical specifications and guidance documents for CCO incentive measures*. Website. http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

Rhode Island

Background

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (DBHDDH) is a separate cabinet-level department whose mission is "assuring access to quality services and supports for Rhode Islanders with developmental disabilities, mental and substance use disorder issues, and chronic long term medical and psychiatric conditions."[72]

The Department, specifically the Division of Behavioral Care, administers a system of care that provided clinical treatment services and supports for over 43,000 individuals in fiscal year 2013. Six regionally based community mental health organizations (CMHOs) and three other specialty CMHOs are responsible for the provision of all outpatient public mental health services in the state's eight catchment areas. Substance use disorder services are provided through five prime contractors serving five regions of the state; however, there are many other substance use disorder providers in the state, including Medicaid-funded providers. The Department funds a single, statewide medical detoxification and acute psychiatric hospitalization program, substance use disorder treatment programs at 6 men's and 6 women's adult residential treatment facilities, and Medication-Assisted Treatment (MAT) at 6 agencies with 12 sites.

Medicaid Expansion and Health Homes

Rhode Island was one of the first states to implement the Affordable Care Act option of expanding Medicaid to cover single adults earning up to 133 percent of the federal poverty level. The expansion of Medicaid significantly increased the number of consumers with mental and substance use disorders (M/SUDs) in Rhode Island who were eligible for Medicaid services. Rhode Island originally offered behavioral health Medicaid benefits from a carve-out managed care system that had two managed care organizations (MCOs) responsible for behavioral health benefits. With the expansion of Medicaid, behavioral health benefits became part of a carved-in managed care system; that is, behavioral health benefits are now managed along with all other health benefits. To date, there are a select number of services that have yet to shift to the carve-in model, as transitions are ongoing.

Rhode Island was one of the first two states in the nation to implement health homes for behavioral health. In addition, Rhode Island is using CMS funds to support the implementation of health homes for specialty populations, inclusive of behavioral health. The state has three approved State Plan Amendments (SPAs):

- The first SPA is for individuals with serious and persistent mental illness (SPMI). Health home services will be provided by seven CMHOs.

[72] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals. *Who we are*. Website. http://www.bhddh.ri.gov/about/mission/mission.php

- The second SPA is for an opioid treatment program (OTP) health home, which was approved July 2013. This health home specializes in children and adolescents younger than 21 years. Services will be provided by Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation Family Centers (CEDARRs).
- The third SPA is for individuals with SPMI and/or other disabling or chronic physical or developmental conditions.

The SPAs provided an opportunity to support integration by aligning data from MCOs, providers, Medicaid, and the state. Rhode Island collaborated closely with local providers, specialty organizations, and the Department of Human Services during the preparation for and implementation of coordination of care. Other state agencies, consumers and families, and technology experts were also consulted during the planning process. Rhode Island benefitted from a close partnership with external agencies and entities from the planning phase to the current training phase of implementing a health home model.

An important aspect of Rhode Island's reform is a 5-year Global Consumer Choice Compact Waiver approved by CMS in early 2009. Rhode Island operates its entire Medicaid program under this waiver. The waiver ensured that enrollment was either in the capitated or fee-for-service (FFS) managed care model. Rhode Island also is part of the CMS Multi-payer Advanced Primary Care Practice Demonstration that provides a monthly care management fee for Medicare enrollees in advanced physical health care practices. Additionally, the state has a Money Follows the Person grant to assist efforts in returning institutional residents to health and supportive care in the community. The state also is working with CMS on the population of individuals who are dually eligible for Medicare and Medicaid.[73]

Health Home Funding

The two health home SPAs will have different payment structures: one uses a monthly case rate and the other (CEDARR Health Home) uses fee-for-service payments. Block grant funds are currently used to pay for health home-like services for people who are not eligible for Medicaid. Commercial insurance does not cover health homes. Two of the CMHOs providing physical care are partially funded through a SAMHSA grant. Peer specialists are not currently billable under Medicaid, but the state is planning to have them certified for Medicaid billing in the future. Peer specialists are being incorporated into the health home rate as part of health home team.

Health Home Outcome Monitoring

Rhode Island is measuring all of the health home outcomes and performance measures as required by CMS. To do so, the state is using an in-house designed Heath Information Exchange (HIE) to analyze data. They are using five quality-improvement goals for CEDARR Health

[73] Spillman, B., Ormond, B., & Richardson, E. (2012). *Medicaid Health Homes in Rhode Island: Review of pre-existing state initiatives and State Plan Amendments for the state's first Section 2703 Medicaid Health Home*. Washington, DC: Urban Institute. Retrieved from http://aspe.hhs.gov/daltcp/reports/2012/HHOption-RI.pdf

Homes and six for CMHO Health Homes. Improved quality of care is indicated by outcome measures that include improved care coordination, reduced secondary conditions, reduced emergency room use, and improved prevention services.[74] Patient satisfaction surveys are also a major source of data to monitor the effectiveness of health homes.

Health Information Exchange and Data Sharing

Rhode Island uses the HIE to connect client data across a number of different systems and services. Information is shared in real time between managed care organizations and Rhode Island's behavioral health agency data system. MCOs are responsible for sharing information with the DBHDDH as part of provider agreements. The integrated data within the system relies heavily on participation from the MCOs, because the information is held directly by these entities. Data are not shared automatically, with the exception of flagging a client who has a mental health condition; rather, approval is needed from the MCOs to allow data to be shared. MCOs provide quarterly reports to providers and the DBHDDH about utilization of health homes, including prescription information. In addition, the MCOs can identify clients of a health home through the DBHDDH Client Information System, and they can identify where services are being rendered.

Key Barriers

One major barrier has to do with change and the cultural shift of working toward a whole-health integrated system. Physical health care providers are often leery of the accountability of behavioral health providers in the physical health world. It took many meetings with CMHCs, hospital liaisons, and physical health care providers to work through a collaborative understanding and approach to design an integrated care system.

Another barrier noted by Rhode Island is that CMHCs often view themselves as already providing behavioral health services as well as physical health care and other health services within the integrated model environment. The CMHCs did not see a need to work collaboratively with physical health care systems.

Lessons Learned

Rhode Island recommends that states should not underestimate the time it takes to implement health homes, because this has been one of the major accomplishments of establishing an integrated approach to care. Rhode Island learned that a statewide project director was needed to work with providers on the approach.

Rhode Island also suggests that implementation teams at the state level should ensure that the health home teams have physical health care decision support capacities with the right type of physical health care medical staff resources. Rhode Island notes that this is essential to systematically implementing the required standard of quality care coordination. To this end,

[74] National Academy for State Health Policy. *Rhode Island*. Website. http://www.nashp.org/med-home-states/rhode-island

Rhode Island suggests that health homes require a separate infrastructure with regard to staffing and other activities (e.g., medical expertise, documentation development, data tracking) and that these processes need to be embedded within other evidenced-based services (e.g., Assertive Community Treatment, Integrated Medicare-Medicaid Treatment, Supportive Employment).

Rhode Island also noted that other states should not underestimate the degree to which an integrated health home or clinical team must improve on their current organization and communication processes. Rhode Island found that teams need to produce intense, well-organized, evidence-based treatment and rehabilitation services while addressing a range of medical care coordination issues. Moreover, Rhode Island recommends that there is a focus on developing the health literacy of the case workers and on the use of stage-appropriate health coaching technologies and strategies.

Rhode Island learned that there were significant start-up costs related to developing an integrated approach to care. To address startup costs, Rhode Island made all providers part of the planning team.

Another key lesson learned was related to electronic health records (EHRs). Rhode Island found that for health homes to provide optimal care, an adequate EHR system is essential to facilitates. Use of EHRs fits into the care coordination and workflow processes.

Rhode Island noted that strong leadership is essential to guide the service process and to ensure that there is no overstrengthening of any one component of the team services. For example, introducing the medical component can create a powerful subculture within the team, which can weaken other service components. In addition, it is recommended that leadership be aware of the process and devote time to train staff about the integrated model of care.

Establishing a relationship with primary care practices (PCPs) is important. Behavioral health systems need to recognize that PCPs have their own way of doing things. It is critical to know how those PCPs practices work, because trust is a key to establishing a collaborative process. Memorandums of Understanding (MOUs) with primary care systems have limited usefulness; what is far more important is the relationship with the PCPs and the understanding of how PCP and behavioral health systems work.

In integrating behavioral health with primary care, goals must include respect for the full citizenship of each consumer and the commitment to help the consumer access good health care based on their individual preferences. For example, a consumer-based approach would help the consumer find a physician of the preferred sex and age or one who works with particular morbidities, even when the community behavioral health organization may have a co-located primary care practice within their agency.

It is important to develop the health literacy of behavioral health case workers. Use of stage-appropriate principles to treat mental illness and implementation of health coaching technologies and strategies optimize the consumer's self-management capacities.

Appendix D. Addressing Challenges

Suggestions from states to support improvement in Behavioral Health Business Practices:

Training and Education

- SAMHSA could greatly assist SBHAs by providing or funding more training and education at the provider level on the importance and methods of timely information sharing and billing practices.
- It would be helpful if SAMHSA could provide curriculum and training for community-based and evidence-based practices.
- It would also be beneficial to the states if SAMHSA provided further clarification on the purposes and roles of the Substance Abuse Prevention and Treatment Block Grant (SABG) and Community Mental Health Services Block Grant..
- Training that promotes a new perspective toward whole-person care would be beneficial.

Networking Opportunities

- National conferences and webinars are helpful in exchanging and disseminating ideas across states. (These conferences have been curtailed in recent years due to funding and federal conference policy changes). SAMHSA could provide significant assistance by once again funding national conferences and webinars at levels they provided in past years.
- SAMHSA could provide opportunities for states to participate in webinars or other types of training to share information about their business practices and performance measurement system.

Standardized Behavioral Health Measures

- The development and support of improved standardized measures for behavioral health used across SAMHSA and other federal agencies would be helpful.
- National-level training or support that focuses on an outcomes structure with financial incentives would be useful.

Information Management Infrastructure

- SAMHSA could provide additional funds for IT infrastructure, including (but not limited to) behavioral health data warehouses, HIEs, EHRs, and web applications. HIE and health IT infrastructure is the glue that often holds the initiatives together.

- Set aside some monies for meaningful use strategies. The Health Information Technology for Economic and Clinical Health (HITECH) Act does not include behavioral health in incentive payments.
- Warm-line telephone services should be expanded. (A warm line is a phone service that allows individuals with mental health and/or substance use conditions to speak with a someone who is in recovery from these conditions).
- SAMHSA and others should continue to support behavioral health and primary care integration efforts.

Suggestions from states support improvement in Health-Behavioral Health Integration:

Training and Education

- Early innovators all requested expert technical leadership and training—including curriculum and best-practice sharing—particularly on implementation of health homes.

More Information From Federal Agencies

- Several innovator states wanted greater clarification on using, tracking, and allocating SAMHSA block grant funds.
- SAMHSA could provide toolkits for culture change and use of the Integrated Illness Management and Recovery (IMR) model as a generalist model.

Coordination Among Federal Agencies

- Coordination of data requirements across SAMHSA, CMS, and other federal agencies is another area of need. Meeting the varied data-reporting requirements of different federal agency funders adds costs and stress for behavioral health systems.
- The SAMHSA and CMS initiatives for individuals who are dually eligible for Medicare and Medicaid and health homes helped bring different state agency leaders together to start the dialog about integration of care.
- It would be helpful for SAMHSA and CMS to develop an integrated strategy for behavioral health data collection.
- SAMHSA and CMS should continue to emphasize that block grant and Medicaid funding services work well from data collection and reporting perspectives.
- It would be helpful to have an overall strategy where SAMHSA block grants and Medicaid-funded services can be coordinated, especially as more states become Medicaid expansion states.

Federal Agency Initiatives

- It would be useful for SAMSHA to focus a greater percentage of the Mental Health and Substance Abuse Block Grants on the prevention of behavioral health conditions. Prevention, when successful, limits the future need for behavioral health services and reduces interactions with criminal justice.
- States noted that CMS is currently open to funding health home services and population management needs, and this climate needs to continue.

Suggestions from states to support improvement in the implementation of EBPs:

Funding

- Start-up funding for states to implement EBPs would be a benefit, so that SBHAs would not need to use general-fund dollars.
- Continued flexibility in funding to assist with new EBPs for services that are not covered by Medicaid is also helpful (e.g., the RAISE project).
- Development of projections of how many children, adolescents, and adults are likely to need various EBP services.
- Recognize that there is still a significant barrier related to Medicare behavioral health treatment. Many of the adults served by SBHAs have Medicare only, and Medicare's reimbursement structure does not fund most EBPs. As a result, there is a cost shift to the state to implement EBPs for the Medicare population. There needs to be a concerted effort to work with CMS to change this policy.
- SAMHSA could help fund reimbursement for non-face-to-face services that can help in providing care to persons with behavioral health conditions, such as approaches using telehealth.
- The provision of flexible funding for services would be beneficial.

Epidemiology/Efficacy

- Epidemiological modeling of the characteristics and projected numbers of individuals that could benefit from specific EBPs would be helpful to their system planning, budgeting, and monitoring. Although most EBPs currently describe the characteristics of clients who can benefit from an EBP, they do not provide good targets for how many people in a population may need specific services.
- SAMHSA's list of EBPs in the NREPP includes too many programs, with variability in the levels of empirical support. States would appreciate SAMHSA's help to identify

which EBPs should receive their focus and support for staff training to implement these EBPs.

Implementation Support

- SAMHSA support for the implementation of overdose education and appropriate use of Naloxone would be helpful in increasing public support.
- Provide ongoing support and encouragement to states to implement EBPs as a way to achieve outcomes and to support data infrastructure to help states demonstrate the results of EBPs.

Appendix E: Semi-Structured State Interview Modules

Implementation of Evidence-Based Practices: 2014 State Profiles of Mental Health and Substance Use Agencies

Semi-structured Interview Questions for Case Studies

On behalf of the Substance Abuse and Mental Health Services Agency (SAMHSA), Truven Health Analytics, the National Association of State Mental Health Program Directors Research Institute (NRI), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) are developing case studies of early innovator state activities to promote the enrollment of individuals into health insurance and Medicaid plans. Selected state case studies will be collected into a special 2014 state profiles report of three policy areas. The policy areas are the implementation of evidenced-based practices, changes to business practices, and behavioral health integration with primary care. The 2014 state profiles case study report is intended to provide useful information for all states as they address these policy areas in the next several years.

Below is a set of questions to guide a dialog between the state profile project research team and staff members from state mental health agencies (SMHAs) and single state agencies (SSAs) to determine the experiences, successes, and barriers that early innovators are encountering.

For each early innovator state, a key contact person will be identified to coordinate dialog. State profile project staff will work with the state contact person to coordinate scheduling of a one-hour call with a team from the state to discuss their experiences in this area. Prior to the call, the set of questions will be shared with the state to help them prepare for the dialog. State profile staff will then complete a draft summary of the call, which they will send to the state for review. If necessary, a follow-up call will be held with the state to elaborate on discussion areas.

Whenever possible, additional documentation will be requested from the state to provide examples from the discussion and to potentially be included as part of the case studies being prepared.

Evidence Based Practice (EBP) Activities of State Agencies: The EBP case studies will focus on how EBPs supported by SMHAs and SSAs are being identified, supported, and delivered and how EBPs are changing with the Affordable Care Act and parity.

1. *What mental health and substance use disorder EBPs are the SMHA and SSA formally supporting?*
   A. List of EBPs identified by the state agencies
   B. How is the state supporting the EBPs?
      a. Financing

i. Is the SMHA or SSA offering any special funding to providers for delivering the EBP?
ii. Are there special or enhanced reimbursement rates available? (e.g., do clinicians providing cognitive-based therapy get an enhanced rate compared with the rate for a normal encounter?)

b. Providing training to providers and clinicians
c. Requiring certification and fidelity measurement
d. Regulations and policies

2. *How are the EBPs supported by states changing based on new insurance policies, particularly parity and the Affordable Care Act?*

   A. What new funding streams are SMHAs and SSAs using?

   B. Are EBPs being included in covered benefits under new insurance offered through the following:

      a. Expanded Medicaid
      b. Marketplace insurance plans

   C. Are EBPs being modified for new insurance or funding streams? If yes, what are the changes?

3. *Fidelity and certification of providers for EBPs*

   A. Does the state require measurement of fidelity in order for providers to bill for the service?

   B. Is certification required for reimbursement?

   C. Role of the SMHA and SSA in certification

4. *What training of providers and clinicians is the SMHA and SSA sponsoring or providing to support the implementation of the EBP?*

5. *Outcomes: Is your SMHA or SSA able to document positive outcomes from consumers receiving EBP services? If yes:*

   A. What outcomes are being measured?

   B. How are they measured (data sources)?

   C. What are the findings? Can results be shared with other states?

6. *What barriers is your SMHA or SSA experiencing in making EBPs available to all consumers who need them?*

   A. What resistance to adopting EBPs has the state encountered from providers, how strong has that resistance been, and what steps have been taken to overcome it?

   B. What activities could NRI, NASADAD, the National Association of State Mental Health Program Directions (NASMHPD), or SAMHSA undertake to address these barriers?

7. *What lessons learned from promoting and providing EBPs should be shared with SAMHSA and other states?*

   A. What documentation do you have that can be shared in the case study?

Improving Behavioral Health Business Practices: 2014 State Profiles of Mental Health and Substance Use Agencies

Semi-Structured Interview Questions for Case Studies

On behalf of the Substance Abuse and Mental Health Services Agency (SAMHSA), Truven Health Analytics, the National Association of State Mental Health Program Directors Research Institute (NRI), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) are developing case studies of early innovator state activities to promote the enrollment of individuals into health insurance and Medicaid plans. Selected state case studies will be collected into a special 2014 state profiles report of three policy areas. The policy areas are the implementation of evidenced-based practices, changes to business practices, and behavioral health integration with primary care. The 2014 state profiles case study report is intended to provide useful information for all states as they address these policy areas in the next several years.

Below is a set of questions to guide a dialog between the state profile project research team and staff members from state mental health agencies (SMHAs) and single state agencies (SSAs) to determine the experiences, successes, and barriers that early innovators are encountering.

For each early innovator state, a key contact person will be identified to coordinate dialog. State profile project staff will work with the state contact person to coordinate scheduling of a one-hour call with a team from the state to discuss their experiences in this area. Prior to the call, the set of questions will be shared with the state to help them prepare for the dialog. State profile staff will then complete a draft summary of the call, which they will send to the state for review. If necessary, a follow-up call will be held with the state to elaborate on discussion areas.

Whenever possible, additional documentation will be requested from the state to provide examples from the discussion and to potentially be included as part of the case studies being prepared.

Changing Business Practices: The Changing Business Practices Cases Studies will focus on how SMHAs and SSAs are promoting and supporting changes to provider business practices as the provision of health care services evolves. The changing business practices may include information technology, health information systems, quality measurement, and billing practices.

1. *With new insurance and Medicaid coverage, is your SMHA or SSA changing how you contract for the provision of behavioral health services?* For example, do you have any new requirements or procedures to make sure that new insurance (Medicaid and other) is billed first for services before state funds or block grant funds are used to pay for services? If yes, describe.

2. *Is your SMHA or SSA changing its billing and/or billing compliance systems?* If yes, please describe the changes being made.

   A. What is covered within the system(s)?

      a. What types of services are covered by the billing system?
      b. What variables are measured by the compliance system?

         i. How often are the variables measured?
         ii. What happens when providers exceed or underperform their goals?

   B. Describe your experience, including any successes and problems.

   C. What lessons did you learn from your experiences with billing or the compliance system(s) that could be shared with SAMHSA and other states?

   D. Please provide any written documentation about your billing or compliance system(s) activities.

3. *Is your SMHA or SSA changing its Health Information Technology (HIT) system(s), including the implementation and use of electronic health records (EHRs)*

   A. Describe your procurement process.

   B. Describe the features and benefits of your HIT.

   C. What lessons can be learned from your HIT experience that could be shared with SAMHSA and other states?

   D. Please provide any written documentation about your HIT activities.

4. *EHRs and electronic medical records*

   A. Does your SMHA require community mental health (and substance use disorder, where appropriate) providers to use a single state-identified or state-operated EHR for SMHA clients? Or, do providers select and operate their own (not standardized across the state) EHR systems?

      a. If the state has a required EHR system, do some providers also have their own EHR system? That is, do they need to operate two EHRs—one for state reporting and one for non-state clients?
      b. Does the SMHA or SSA help financially support an EHR system for community providers? How is this handled?

   B. Please discuss how the Office of National Coordinator (ONC) standards for meaningful use are being addressed? Can you system currently meet Stage 1 and/or Stage 2 standards for exchanging EHR information and Continuity of Care Document (CCD) information?

a. If yes, is your system using either Direct Secure Messaging or the Exchange Protocols that are part of meaningful use?

   i. If not, what are the barriers or limitations that are preventing this use?

C. Are you or your providers connecting to a Health Information Exchange (HIE)?

   a. If yes, please describe what types of EHR data are exchanged, with whom data are shared through the HIE, and how consumer consents are addressed.

      i. Has your system experienced any issues or delays with exchanging data because of the confidentiality requirements for mental health (and/or substance use disorder) records? If yes, how are you addressing these issues?

5. *Please describe how your SMHA or SSA is changing or improving your business practices in providing (or ensuring the quality provision of) behavioral health services.*

6. *What lessons did you learn from changing your SMHA or SSA business practices that can be shared with SAMHSA and other states?*

   A. What documentation do you have that can be shared in the case study?

Behavioral Health and Health Care Integration: 2014 State Profiles of Mental Health and Substance Use Agencies

Semi-Structured Interview Questions for Case Studies

On behalf of the Substance Abuse and Mental Health Services Agency (SAMHSA), Truven Health Analytics, the National Association of State Mental Health Program Directors Research Institute (NRI), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) are developing case studies of early innovator state activities to promote the enrollment of individuals into health insurance and Medicaid plans. Selected state case studies will be collected into a special 2014 state profiles report of three policy areas. The policy areas are the implementation of evidenced-based practices, changes to business practices, and behavioral health integration with primary care. The 2014 state profiles case study report is intended to provide useful information for all states as they address these policy areas in the next several years.

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Whenever possible, additional documentation will be requested from the state to provide examples from the discussion and to potentially be included as part of the case studies being prepared.

Health–Behavioral Health Integration: This case study will focus on SMHA and SSA activities around health–behavioral health integration, integrated service coverage, delivery system, payment, information sharing, care coordination, and quality measurement initiatives. We want to discuss areas where your state has been successful in integrating care, discuss factors that contributed to the success, identify barriers encountered, and describe your state's recommendations for what could assist states in addressing these barriers.

1. *What types of health–behavioral health integration activities are your SMHAs and SSAs undertaking?* These can include services, care coordination, delivery systems, quality measurement, value-based purchasing or bundled reimbursement, and information sharing. We are interested in efforts to better integrate behavioral health care into primary care

settings and in efforts to integrate primary care into behavioral health settings. Please describe activities in your state to integrate both sides of general health care and behavioral health care.

A. Is the activity statewide or local?

B. Do you track the number of people served by an integrated system?

   i. If so, do you have an approximate number of those served?
   ii. Are there specialty populations you may be targeting for your integration efforts?

      1. Children
      2. Older adults
      3. Individuals with dual diagnoses (mental and substance use disorder)
      4. Veterans
      5. Other: describe

C. Describe how the SMHA and SSA promote or manage integration efforts.

D. How do you measure your integration efforts? (please describe)

E. Are you using a control group or data sample?

   i. Are your integration efforts producing better outcomes for individuals not served by an integrated system? (Discuss pre- and post-test or local integration efforts.)

      1. What types of outcomes are you measuring?

         a. Money savings to the state
         b. Fewer visits to emergency departments
         c. Reduced psychiatric hospitalizations
         d. Improved care coordination
         e. Improved consumer outcomes and improved functioning

2. *Does your state have any specialty populations that are targets of your integration efforts? For example, patients with specific medical and behavioral health comorbidities.*

   A. If yes, what are the specific target populations? How did you select these client populations? (e.g., were they identified because of high costs, intensive service use, or poor outcomes?)

3. *Is your state implementing health homes that include behavioral health services (a provision of the Affordable Care Act)?*

   A. Are they implemented locally or statewide?

   B. Is primary care co-located in community mental health centers (behavioral health homes)? Is this a statewide initiative or locally based?

C. Conversely, does the state require the inclusion of behavioral health providers in community health centers (primary medical home model)? If yes, please describe your experience in getting behavioral health included in these health homes.

4. *Health–behavioral health integration activities (other than health homes)*

A. Please describe activities (other than health homes) your SMHA or SSA is supporting to integrate primary care **into your community mental health system.**

i. What specific integration activities are underway?

ii. How are these integration activities financed or reimbursed?

1. Are there special reimbursement rates or bonus incentives for behavioral health providers that are integrating health services?
2. Does your state provide any kind of incentives to behavioral health providers to obtain and implement the technology they need to do this work?

iii. What outcomes are you monitoring or measuring?

1. Is there an alignment with what the state is requesting from providers in terms of quality measures and meaningful use? (e.g., if physicians are claiming or billing for meaningful use incentive payments, are they reporting the same measures?)
2. Are you utilizing any procedural measures because of the absence of appropriate outcome measures?
3. Are other outcome measures in development?
4. Do you have results that can be shared?

B. Please describe activities (other than health homes) your SMHA or SSA are supporting to integrate behavioral health care services **into your state's primary care system** (including work with federally qualified health centers [FQHCs]).

i. What specific integration activities are underway?

ii. How are these integration activities financed or reimbursed?

1. Are there special reimbursement rates or bonus incentives for providers that are integrating behavioral health services?

iii. What outcomes are you monitoring or measuring?

1. Are you using any procedural measures because of the absence of appropriate outcome measures?
2. Are other outcome measures in development?
3. Do you have results that can be shared?

iv. How would you describe the "environment" between FQHCs and behavioral health providers? Are they generally cooperative and integrating well? Or are they

engaging in turf wars and not really integrating (or somewhere in between)? Can you provide examples of where and why the environment is working well or not?

5. *Is your state providing or supporting a specific patient registry function that supports the integration between medical and behavioral health providers?*

   A. If yes, please describe the registry—was it built by the state or purchased commercially?
   B. How was the registry financed?
   C. How well is it working? Are both medical and behavioral health providers using it equally?

6. *What training is the SMHA or SSA providing to support health–behavioral health integration?*

   A. This may include specific training for providers (e.g., use of standardized screening tools)
   B. Peer support training

7. *Are there barriers your SMHA or SSA is encountering in response to your health–behavioral health integration efforts?*

   A. How could the barriers be reduced or eliminated? Are any of those barriers caused by provider, member, or patient resistance? If so, how strong has that resistance been and how has it been resolved?
   B. What activities could NRI, NASADAD, NASMHPD, or SAMHSA undertake to address these barriers?

8. *What lessons can be learned from your health–behavioral health integration experience that should be shared with SAMHSA and other states?*

9. *Please provide any written documentation about your health–behavioral health integration activities.*

Appendix F: Contributors

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