MONTANA HEALTHCARE FOUNDATION

Integrated Behavioral Health In Montana: A Baseline Assessment of Benefits, Challenges, and Opportunities

April 2016

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Methods

To develop this report, the Montana Healthcare Foundation took a multi-pronged research and data collection approach that included:

- A review of key documents and research related to Integrated Behavioral Health at both the state and national levels
- An electronic survey of the baseline level of behavioral healthcare integration in Montana, sent to Montana's community mental health centers, substance abuse disorder treatment programs, federally-qualified health clinics, urban Indian clinics, tribal and Indian health service clinics, and hospital affiliated primary care clinics
- Key informant interviews with Montana providers, advocates, insurers and state officials, and
- Key informant interviews with national experts working in Integrated Behavioral Health

Findings from this research were compiled and are presented in the following document. The Montana Healthcare Foundation contracted with an independent consultant to research and write this report.

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Introduction

"I never understood the arbitrary distinction in medicine of 'above the neck and below the neck'. If you understand the mechanics of the mind-body link, then you know you can't divorce physical and psychological health. We've all worked in traditional primary care setting and the model is ineffective. The only way to move the needle on any of these conditions is to really treat the whole person, and this can only happen in an integrated setting."

-Dr. David Mark, CEO of the Bighorn Valley Health Center in Hardin, Montana

Over the past decade, the concept of Integrated Behavioral Health has emerged as a prominent issue in the national healthcare systems design discussion. As evidenced by the quote above, primary care providers in Montana and across the U.S. are discovering integration as a means to better care for a range of health conditions. Innovative models being implemented nationwide are using integration as the bedrock of larger health systems change designed to better serve all clients with complex healthcare needs, including those with severe and disabling mental illness and substance use disorders. The federal Agency for Healthcare Research and Quality (AHRQ) defines Integrated Behavioral Healthcare as:

The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.[1]

As this definition makes clear, behavioral health encompasses both mental health and substance use, as well as health behaviors and life skills. When clinicians with expertise in behavioral health are incorporated into a care team in a primary care setting — or vice versa, -when primary care providers are incorporated into the care team in a behavioral healthcare setting — then the system is moving toward an Integrated Behavioral Health model. Robust Integrated Behavioral Health systems are characterized by a number of features. Not only do these systems have behavioral health and primary care providers in the same location providing team-based care that is patient-centered, but the systems of care are integrated at every level, from appointment scheduling, shared waiting rooms, integrated patient assessment and diagnostic tools, all the way to treatment planning and follow-up. Integrated healthcare organizations may utilize case managers, community health workers, or even pharmacists as part of the healthcare team to provide wrap-around care to patients and support clinical decision-making. A critical component of integration is the ability to track patient populations using data that facilitates systematic follow-up and relapse prevention, as well as more seamless communication and care coordination. Best practice models of integration utilize evidence-based tools and practices for assessment, diagnosis and treatment, and have effective oversight and quality improvement processes in place. Finally, fully integrated systems in the primary care setting allow for systematic psychiatric review and consultation for complex behavioral health patients so that providers are not asked to operate outside of their scope of care.[2] When mental health care organizations integrate, the consultation provided is from primary care providers who assist in the care and treatment planning of patients with complex chronic healthcare conditions.

The need for more integrated healthcare systems is evidenced by the health disparities experienced by individuals who suffer from behavioral health concerns, many of whom must currently navigate very complex systems of care at multiple service sites in their community in order to address their healthcare needs.

"People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care. At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. The solution lies in integrated care, the systematic coordination of general and behavioral healthcare…. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs."

-HRSA-SAMHSA Center for Integrated Health Solutions[3]

The Integrated Behavioral Health model is now supported by a number of state and national level efforts, and a body of research is emerging documenting how these systems improve patient outcomes and lower costs.[4] A recent meta-analysis of randomized control trials found that integrated care interventions resulted in significantly better behavioral health outcomes overall, particularly for children with an existing mental health diagnosis.[5] Studies in adults have also shown significant improvement in patients' physical, behavioral, and overall health, and a positive return on investment and cost savings for patients served under integrated models, including reductions in hospital stays.[6]

Despite national movement toward more widespread implementation of Integrated Behavioral Health, efforts to create a more integrated system of care in Montana are still at an early stage of development. Montana is one of only five states that does not have at least one coordinated Integrated Behavioral Health activity identified in AHRQ's Integrating Behavioral Health and Primary Care Academy, a national database of integrated behavioral health initiatives.[7] The reasons for Montana's lack of robust integrated care systems are complex and will be explored in this report. One basic challenge is that the publically funded health services for substance use treatment and mental health are not integrated in Montana, so our state lacks a coordinated behavioral health system, let alone a system that seamlessly integrates substance abuse, mental health and primary care systems.

Having identified behavioral health as a key concern for the state and integration as an evidence-based practice for both improving overall health outcomes and reducing and controlling healthcare costs, the Montana Healthcare Foundation plans to work with partners to address this gap in coordination in our state. The Montana Healthcare Foundation will invest in piloting the use of Integrated Behavioral Health in Montana and, more broadly, in facilitating coordination and strategic planning that includes multiple stakeholders and results in a practical plan to strengthen Montana's system of care. The following report is a baseline assessment of the use of Integrated Behavioral Health in Montana that can inform the strategic work to which the Foundation will contribute, along with a robust group of partners, to encourage the development of more Integrated Behavioral Health systems that improve health outcomes statewide.

Why Behavioral Health?

Designing better systems to address behavioral health concerns in Montana is critical because our state suffers from high rates of mental illness and substance abuse disorders. According to the 2013 Behavioral Risk Factor Surveillance Survey (BRFSS), one in five Montana adults reports ever having had a depressive disorder, and 32% report having had at least one poor mental health day in the last month. One in five Montana adults reports binge drinking (20.8%), compared to 16.8% of adults in the U.S. overall, and 7.7% of adults in Montana are classified as "heavy drinkers," significantly higher than the U.S. rate of 6.2%.[8] Montana youth also report substantial concerns related to mental health and substance abuse. More than one in four high school students (26.4%) report symptoms consistent with depression in the last year, and 70.5% of high school students report having ever used alcohol, significantly higher than the overall U.S. rate of 66.2%. Thirty-seven percent of high school students in Montana report alcohol use in the past month, and 23.5% report binge drinking during the same time period. This means that, of the high school students who are currently using alcohol, 63% are engaged in binge drinking behavior.[9]

Though high rates of alcohol use are the primary factor driving Montana's elevated rates of reported substance abuse, illicit drug use is also a concern in this state. One in five high school students reports current marijuana use (21.0%), one in 10 reports lifetime inhalant use (9.9%), and 16.2% report abuse of prescription drugs in their lifetime.[10] The concerning trends in illicit drug use continue into adulthood: according to the 2012-2013 National Survey on Drug Use and Health, almost one in four young adults in Montana reports illicit drug use in the past month, including 23.0% of young adults who report currently using marijuana. Montana is consistently ranked in the top 10 states in terms of risk factors for alcohol use among our 18- to 25-year-old adults.[11]

Nationally and in Montana, substance abuse and mental health diagnoses are often linked. Individuals who report mental health concerns are also much more likely to abuse substances and vice versa. In 2014, the National Survey on Drug Use and Health found that 39.0% of adults with a substance abuse disorder also had a co-occurring mental illness. Co-occurring substance abuse disorders were also present in 18.0% of adults with mental illness.[12] In a 2012 analysis, more than 30.0% of adolescents on Medicaid and CHIP (Children's Health Insurance Program) aged 17 and 18 treated for behavioral health issues in Montana had a co-occurring diagnosis.[13] The cost of treating complex co-occurring disorders is high. In the 2012 analysis, the average annual cost of care for an adolescent in Montana on Medicaid with a co-occurring diagnosis was $16,719, compared to $1,385 for an adolescent with only a chemical dependency diagnosis, and $6,966 for adolescents being treated for mental illness alone. The study found that, for all adolescents aged 11 to 18 on Medicaid and CHIP in Montana with behavioral health concerns, individuals with co-occurring illness made up 10.8% of the total study population, but accounted for 26.0% of the total expenditures.[14]

Individuals with behavioral health concerns are often affected by other medical conditions as well. A recent national co-morbidity study found that 68.0% of adults with a mental illness also had at least one additional medical condition.[15] In 2011, almost one in five Americans, a total of 34 million adults, had co-morbid mental health and medical conditions.[16] A 2014 report for the American Psychiatric Association found that "Medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be two to three times as high as those beneficiaries who don't have the co-morbid MH/SUD conditions. The additional healthcare costs incurred by people with behavioral co-morbidities are estimated to be $293 billion in 2012 across commercially-insured, Medicaid, and Medicare beneficiaries in the United States."[17] Clearly, mental health, substance abuse disorders, and other medical conditions do not occur in isolation, and treating these co-occurring and co-morbid conditions is costly under the current system.

The high rates of substance abuse and mental health concerns in Montana have devastating consequences in the lives of those individuals who suffer from them. The adult suicide rate in Montana is consistently twice the rate

in the United States as a whole. In fact, in 2013, Montana had the highest rate of suicide of any state in the U.S. at 23.72 per 100,000 compared to 12.6 per 100,000 for the U.S. as a whole.[18] Montana also has the second-highest rate of alcohol-related deaths in the U.S.[19] The link between mental health, substance abuse, and suicide is clear. Forty-eight percent of suicide victims in Montana have alcohol in their systems at the time of death, 21.0% have narcotic pain killers, and 17.0% have marijuana in their systems. Under-diagnosis of mental health issues and high rates of alcohol and drug abuse contribute to the suicide epidemic in Montana; only 40.0% of people who commit suicide in the state have an identified mental health diagnosis at the time of death.[20]

Because of these concerning public health statistics, the Montana Healthcare Foundation has identified behavioral health as one of its core areas of focus. The mental health and substance abuse statistics summarized here highlight the need to create a behavioral health system in Montana that:

1. Identifies signs and symptoms of mental illness and substance abuse disorders early on;
2. Links affected individuals to evidence-based treatment for these health concerns; and
3. Increases the number of providers and healthcare facilities that integrate primary care, mental health, and substance use treatment services; *i.e.*, that provide integrated behavioral health.

To fully understand why it is critical to improve the systems of care in Montana for behavioral health, it is important to understand how the current systems are structured.

The Behavioral Health System in Montana

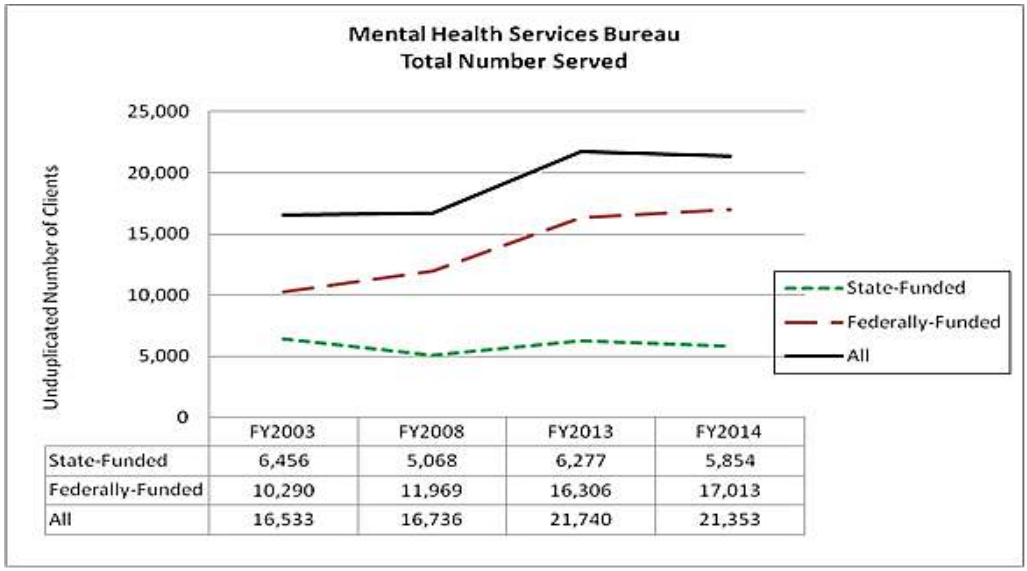
The Montana Government's Public Mental Health Treatment System

Many of the services provided to Montanans with mental health and substance use disorders are paid for by programs administered by the Montana Department of Public Health and Human Services (DPHHS). This system can be thought of as the "public" behavioral health system in our state and includes those individuals whose behavioral healthcare is paid for by the Medicaid program, the state-funded Mental Health Services Program (MHSP), state general fund money allocated for substance abuse treatment or mental health services, or through federal block grants, as well as the work DPHHS does to license and support mental health and substance use treatment service providers statewide. Within DPHHS, public mental health and substance abuse disorder services for adults are coordinated in the Addictive and Mental Disorders Division (AMDD), which houses the Mental Health Services Bureau (MHSB) and the Chemical Dependency Bureau (CDB). The Children's Mental Health Bureau (CMHB) is located in a separate division, the Developmental Services Division (DSD). Each bureau has separate rules and administrative procedures for reimbursement and service provision. A summary of the services and payments coordinated by these programs is shown below. The Veterans Administration, Indian Health Service, and tribal health programs also provide certain behavioral health services; these services, and opportunities to strengthen and better integrate them with the state system, will be explored in depth in a future MHCF report.

The core mental health services, which vary based on diagnosis and need, administered through the MHSB and the CMHB, are funded through Medicaid reimbursement, as well as through state-funded mental health services for children not eligible for Medicaid and the Mental Health Services Plan (MHSP) for adults. The Montana Medicaid program has a Basic 1115 Wavier which allows adults in Montana who are low-income, not otherwise eligible for Medicaid, and who meet the state's definition of SDMI as defined in Montana Administrative Rule 37.86.3503,[21] to receive Medicaid coverage. Montana has requested an expansion of this waiver to serve any adults meeting the SDMI criteria regardless of income. Montana also operates the state-funded MHSP to provide limited mental healthcare coverage to individuals age 18 or older with SDMI and incomes of 0-150.0%

of federal poverty level residing in detention or pre-release settings. MHSP does not cover any physical health-care or inpatient services but does cover outpatient mental health services and prescription drugs up to $425. Currently, around 800 adults with SDMI are covered under the MHSP. The number of individuals covered under the Basic Waiver and the MHSP are likely to change with the recently passed Medicaid expansion bill, the HELP Act, in Montana. This may cause Montana to reevaluate these programs and their eligibility criteria. Some policy changes are already underway. In January 2016, Montana extended coverage under the Basic 1115 Waiver to adults aged 65 and over up to 150.0% of the federal poverty level, a group that had not previously been eligible for coverage under this program.

Montana's Medicaid program is fee for service, providing reimbursement for a continuum of mental health services from community-based to inpatient. Medicaid reimbursement for mental health services is provided to any adult or child on the program who is diagnosed with a mental health disorder, as well as up to 2,000 additional adults with SDMI who qualify under the 1115 Waiver. Montana also has a Home and Community Based Services waiver that allows adults with SDMI and children with Serious Emotional Disturbance (SED) to receive the mental health services necessary to live in the community versus in an institution. In fiscal year 2014, 21,353 adults with SDMI received services through the MHSB in Montana (either through Medicaid or the MHSP), including early intervention programs, crisis services, core mental health treatment, and transitional and recovery programs. This represents a 29.0% increase in the number of individuals receiving services since 2003, when the number was only 16,533. With the Medicaid expansion bill recently passing in Montana, the number of adults on Medicaid, as well as those needing treatment for SDMI, will increase. The total cost of the care provided in 2014 for adults with SDMI on Medicaid was more than $69 million. In all, just over 65,000 adults are enrolled in Medicaid in Montana, which means that, of the adult case load in this state, 32.0% received treatment for SDMI in the last year alone, indicating that SDMI is one of the primary medical concerns among adults in Montana on Medicaid.



	FY2003	FY2008	FY2013	FY2014
State-Funded	6,456	5,068	6,277	5,854
Federally-Funded	10,290	11,969	16,306	17,013
All	16,533	16,736	21,740	21,353

[22]

The core public mental health services for children are also funded through Medicaid, with state funds matched by federal dollars. Children who meet the criteria of state's definition of Serious Emotional Disturbance (SED)[23] are eligible for extended mental health benefits under Medicaid and the State-Children's Health Insurance Plan (S-CHIP). Extended mental health benefits include home support services/therapeutic family care, out-of-home care (including acute psychiatric hospitalization, psychiatric rehabilitation treatment, therapeutic group homes, youth day treatment, respite care and community-based psychiatric rehabilitative and support (CBPRS), in addition to the pharmacy services), inpatient mental health services, and individual, family, and group psychotherapy

office visits offered to all Medicaid and S-CHIP recipients.[24] In terms of mental health services for youth, in state fiscal year 2014, the CMHB managed and funded mental health services for over 16,700 youth with SED enrolled in Medicaid or S-CHIP. With around 89,000 children currently enrolled in Medicaid or S-CHIP program, this means that 19.0% of the current Medicaid case load for children is receiving treatment for SED. The total cost in 2014 for Medicaid's mental health services for youth was $122 million.[25]

Children and adults with mental illness on Medicaid can receive mental health services in a wide variety of settings. The State of Montana has a network of 25 mostly not-for-profit mental health centers across the state that provide community-based mental health services on a sliding fee schedule. These mental health centers can be licensed for a range of services, from adult and youth intensive case management and day treatment to inpatient and secured crisis stabilization and mental health group home services. It is important to note that community mental health centers serve clients with a wide range of mental health needs, not just SDMI and SED, and that they accept clients with all forms of insurance, including Medicaid and third-party insurers. Eight community mental health centers in Montana provide mental health services to both children and adults. Eleven of the centers serve only children and six serve only adults. Many community health centers are licensed in more than one city in Montana, providing services across a specific region or throughout the state. In contrast to Federally Qualified Health Centers (FQHCs) on the primary care side, community mental health centers do not receive federal grants or enhanced reimbursement rates to offset the high rates of uncompensated care provided. Several mental health center administrators interviewed for this project noted that the lack of adequate reimbursement for services provided in community mental health centers in Montana places them in a financially vulnerable position and contributes to workforce concerns as the organizations struggle to pay providers competitive wages. A list of the community health centers in Montana is located in Appendix A.

Outside of community mental health centers, children and adults on Medicaid can receive mental health services through any licensed healthcare provider in Montana qualified to treat mental illness and who accepts Medicaid, the MHSP or S-CHIP for children on that program. Consequently, much of the mental health care service provision occurs in primary care practices or with private therapists and other licensed providers who likely also accept clients with private insurance. Another site where individuals in Montana may access mental health services is in Federally Qualified Health Clinic, or community health clinics, as they are often known in Montana. According to the Montana Primary Care Association, "Community Health Centers are not-for-profit, consumer-directed health care organizations that provide access to high quality, affordable, and comprehensive primary and preventive medical, dental, and mental healthcare. Community Health Centers exist to increase healthcare access for underserved, underinsured and uninsured people."[26] FQHCs receive federal grant dollars and enhanced reimbursement rates for care and often serve clients with a team-based approach that includes behavioral health providers. In Montana, 17 community health centers across the state serve approximately 100,000 Montanans.

The Montana Government's Public Substance Abuse Disorder Treatment System

The funding and administration of publicly funded substance abuse disorder treatment in Montana is different from that of mental health services. The Chemical Dependency Bureau (CDB) in DPHHS serves adolescents and adults through both state and federally funded programs. Unlike publicly funded mental health services, which are primarily funded through Medicaid fee-for-service reimbursement for care in a variety of settings, community-based substance abuse services supported by the CDB in Montana are more limited in terms of which providers can be reimbursed for services, the amount of reimbursement for services, and what substance abuse services are reimbursed by the Medicaid program. Importantly, the Montana Medicaid program has historically not covered day treatment and inpatient chemical dependency treatment for adults aged 21 and over. Thus only a fraction of the Medicaid dollars spent on behavioral health in Montana are spent on substance abuse treatment. Annually, adult mental health services are covered by almost $58 million in Medicaid reimbursement for community services. In contrast, Montana receives only $1.3 million in federal Medicaid reimbursement for

substance abuse treatment annually.[27] In lieu of Medicaid spending, Montana has leveraged federal block grant dollars from the Substance Abuse and Mental Health Services Administration (SAMHSA) and from the Substance Abuse Prevention and Treatment (SAPT) Block Grant, along with state general funds and state alcohol tax dollars to pay for services for substance abuse prevention and treatment for adults. Relying heavily on SAPT block grant dollars has left Montana with fewer resources for substance abuse prevention. Montana's current annual budget for primary prevention from the $6.2 million SAPT block grant is $1.2 million, with $5 million allocated for treatment. In 2007, the Montana State Legislature allocated $1.5 million in state revenue annually for methamphetamine and other substance abuse treatment. Additional funding comes from state special revenue from a tax on the sale of alcohol, which yields approximately $5.2 million annually. A portion of this money is allocated to the Montana Chemical Dependency Center, and another portion, pursuant to Montana law, is dispersed to counties through block grants and then directed to state-approved substance abuse treatment providers. The only money truly allocated for behavioral health treatment is a small portion of the alcohol tax dollars, which the Chemical Dependency Bureau uses to fund co-occurring (mental health and substance abuse) treatment contracts.[28] The total annual budget for publically funded, community-based substance abuse treatment services in Montana is $11.2 million (including Medicaid reimbursement, SAPT block grant dollars, state general fund and state special revenue dollars), with another $4.1 million allocated to the Montana Chemical Dependency Center in Butte.[29]

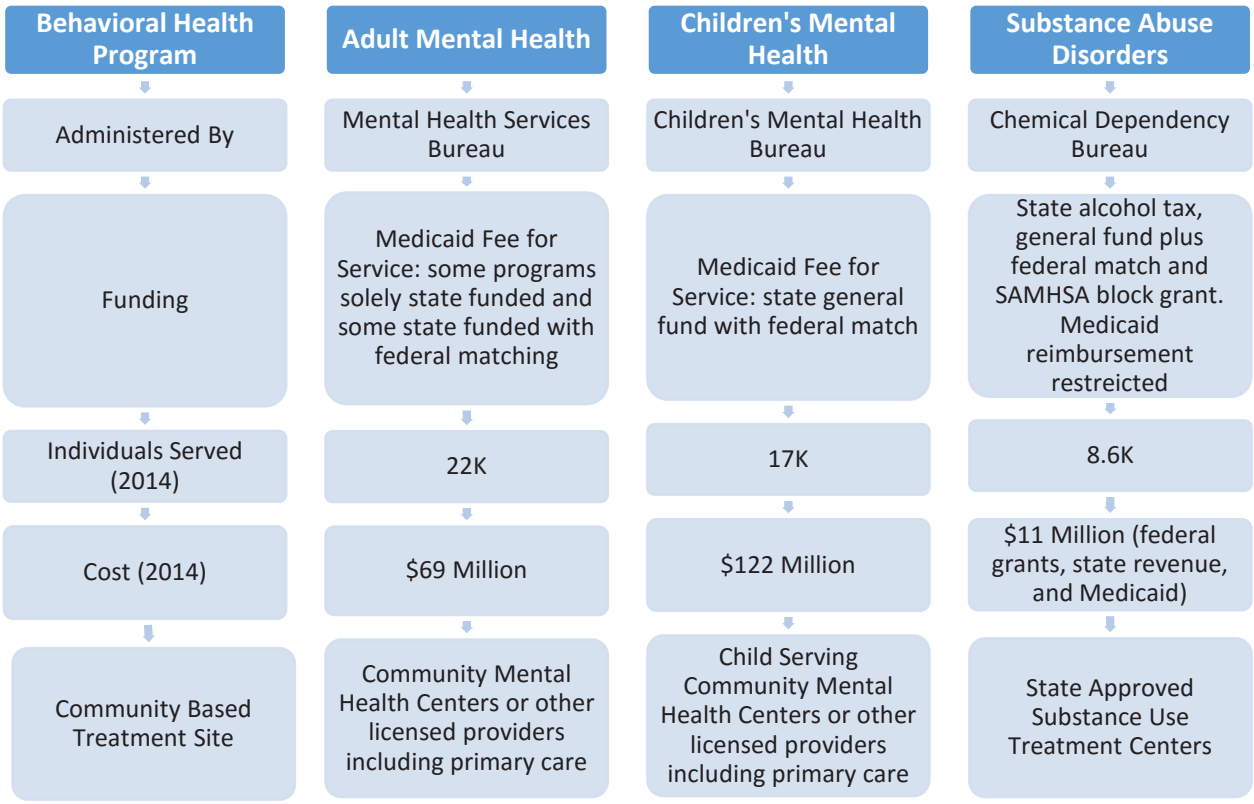
Montana statute (MCA 53-24-208) requires that, "Facilities applying for approval <as state-approved substance abuse treatment facilities> shall demonstrate that a local need currently exists for proposed services and that the proposed services do not duplicate existing local service."[30] Thus, individuals on Medicaid or otherwise receiving publicly funded treatment for substance abuse disorders are currently served at one of only 32 state-approved substance abuse treatment centers in Montana. Only two of these substance abuse treatment centers in the state are also licensed as community mental health centers. A list of the state-approved substance abuse treatment facilities in Montana is located in Appendix B.

Further, the Chemical Dependency services that can be billed to Medicaid are often reimbursed at lower rates than comparable mental health services. For instance, in 2015, the Medicaid fee schedule for 15 minutes of adult Targeted Case Management for Mental Health adults was $17.86, compared to only $9.87 for TCM for Chemical Dependency.[31] As alluded to above, because of the limited funding and reduced reimbursement rates, the state of Montana spends substantially less money on substance abuse disorder treatment annually compared to mental health, with approximately $11.1 million allocated annually for community-based substance abuse treatment, versus $69 million for community-based mental health treatment for adults.

This disparity in funding is also reflected in how Montana ranks in behavioral health spending compared to other states. The Pew Charitable Trusts ranks Montana in the bottom five of all states for overall state funding for substance abuse treatment.[32] In terms of spending for mental health, Montana ranks in the top 10 in terms of per capita expenditures.[33]

With Montana's recent expansion of Medicaid through the HELP Act, DPHHS is reviewing the restrictions in coverage for chemical dependency services for Medicaid adults, and it is possible that the Medicaid expansion may lead to administrative changes that open up the number and kinds of providers that can be reimbursed for Chemical Dependency services provided to Medicaid clients in the state. This change would require revising or rescinding the existing statute.

Figure 1. The Public Behavioral Health System Administration Funding in Montana

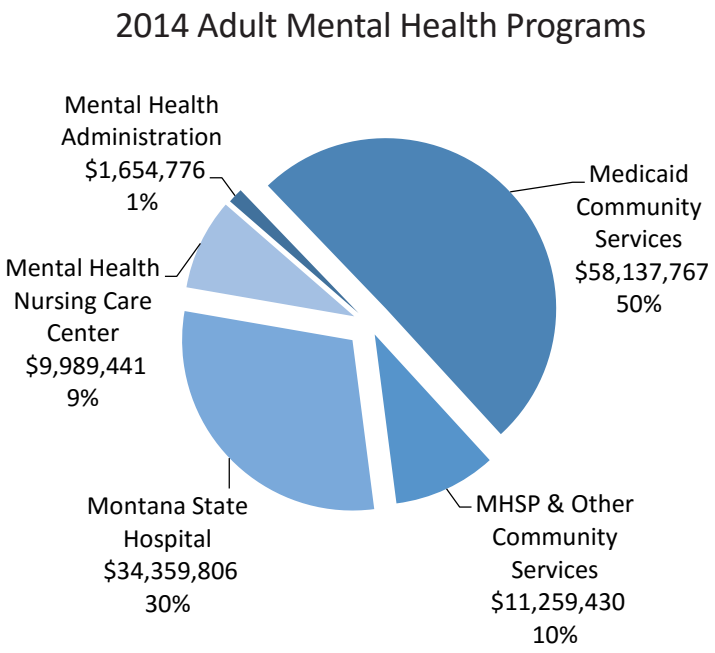


Publically Funded Inpatient and Residential Behavioral Health Treatment Facilities

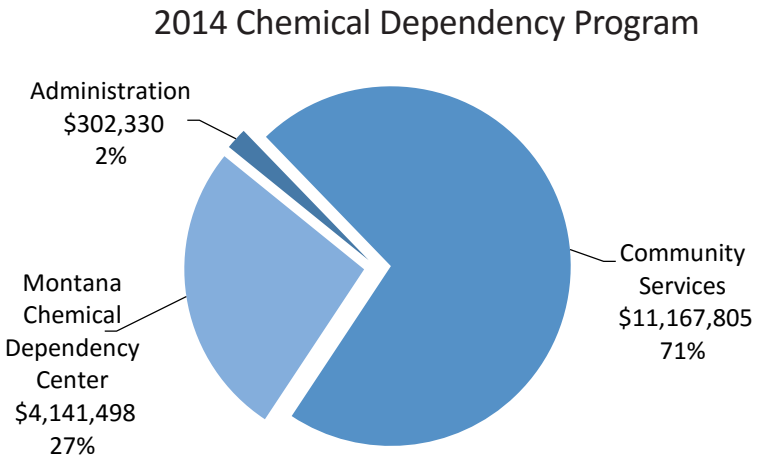
In addition to the community-based services supported and funded by public mental health and substance abuse treatment systems in Montana, DPHHS supports three state-run in-patient facilities for mental health and substance abuse patients. Under the Addictive and Mental Disorders Division (AMDD), three separate facilities operate: the Montana State Hospital in Warm Springs, the Montana Mental Health Nursing Care Center in Lewiston, and the Montana Chemical Dependency Center in Butte. Currently, the Montana State Hospital is operating at maximum capacity. In 15 of the last 17 months, the Montana State Hospital has exceeded its capacity of 208 licensed beds. There was not a single month from July 2014 to November 2015 that the Hospital operated at under 96.0% of its total capacity.[34] Many patients at the Montana State Hospital are forensic patients who are placed there through court orders, and some are Alzheimer's and dementia patients who cannot be effectively served in a community-based setting. However, a portion of this population could be effectively served at the local level if there were more robust primary and secondary preventative behavioral health services available. The cost of running these state-level facilities, as opposed to community-based treatment, is high. The Montana State Hospital and Montana Mental Health Nursing Care Center (which is licensed for 100 individuals) make up 39.0% of the total budget of the AMDD Mental Health programs, and the Montana Chemical Dependency Center (licensed for 48 individuals) makes up 27.0% of the total Chemical Dependency Program budget.[35] Thus, these high-level services, which provide services to only a small fraction of those with behavioral health concerns, account for approximately 1/3 of the total budget spent on public behavioral health services in Montana.

Funding and Per Capita Spending for the Public Behavioral Health System in Montana

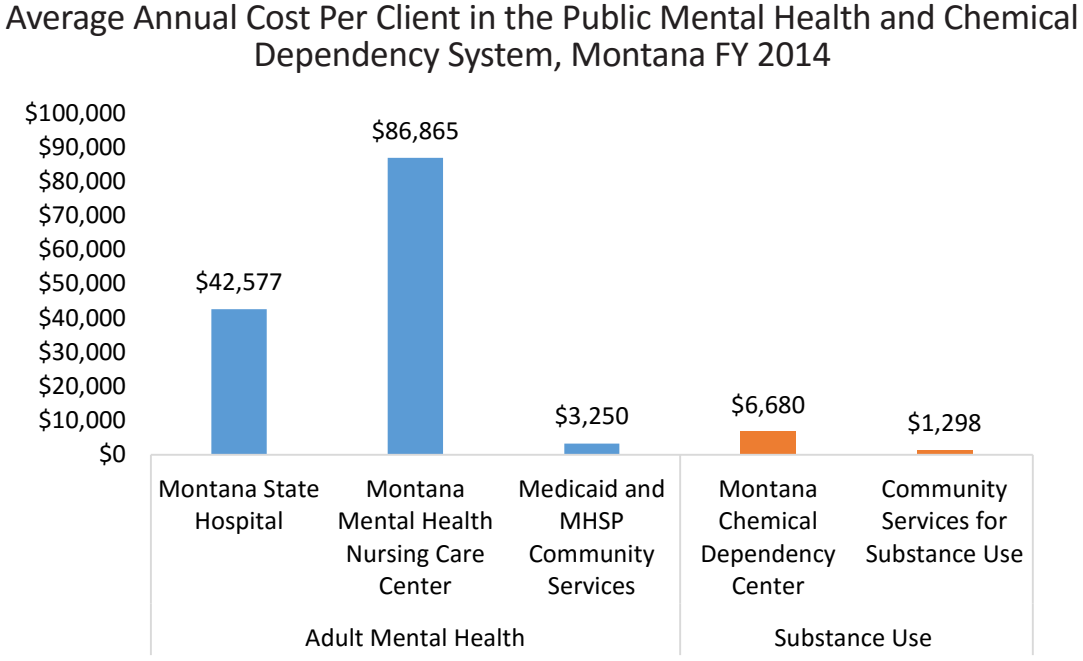
The graphs below depict the total budgets for the various publically-funded mental health and substance abuse treatments services, as well as the cost per client to operate these services.[36]



Facility or Types of Services for Adults Mental Health	Number of People Served (FY 2014)	Total Budget (FY 2014)	Average Cost Per Client
Montana State Hospital	807	$34,359,806.00	$42,577.21
Montana Mental Health Nursing Care Center	115	$9,989,441.00	$86,864.70
Medicaid and MHSP Community Services	21,353	$69,397,197.00	$3,250.00



Facility or Type of Service for Chemical Dependency	Number of People Served (FY 2014)	Total Budget (FY 2014)	Average Cost Per Client
Montana Chemical Dependency Center	620	$4,141,498.00	$6,679.84
Community Services for Substance Abuse Treatment	8,600	$11,167,805.00	$1,298.58



2014 Children's Mental Health Average Costs Per Client, by Type of Service[37]

Facility or Type of Service for Children's Mental Health	Number of People Served (FY 2014)	Total Budget (FY 2014)	Average Cost Per Client
Comprehensive School and Community Treatment	4,913	$32,547,143.00	$6,624.70
Therapeutic Group Home	651	$19,283,729.00	$29,621.70
Psychiatric Residential Treatment Facilities	548	$18,110,870.00	$33,049.03
Home Support Therapeutic Foster Care	1875	$14,117,808.00	$7,529.50
Mental Health Centers	2,452	$7,512,912.00	$3,063.99
Case Management Mental Health	3,945	$7,103,427.00	$1,800.62
Licensed Professional Counselor	6,197	$5,345,057.00	$862.52
Hospital Inpatient	738	$5,143,869.00	$6,970.01
Social Worker	3,561	$2,735,103.00	$768.07
Psychiatrist	2,944	$1,956,647.00	$664.62
Hospital-Outpatient	2,779	$1,483,239	$533.73
Physician	4,896	$1,059,499	$216.40
Mid-Level Practitioner	2,446	$$943,487	$385.73
Psychologist	1,290	$735,794	$570.38
FQHC	856	$537,515	$627.94
Rural Health Clinic	818	$320,675	$392.02
Critical Access Hospital	478	$172,129	$360.10

Behavioral Health in Montana's Public Education and Criminal Justice System

This report did not involve an in-depth analysis of the systems of care for mental illness and substance abuse disorders in the settings of the corrections or public education systems, but both are important to consider to better understand Montana's behavioral health system as a whole.

Several interviewees referred to the large number of incarcerated individuals who are suffering from mental illness and substance abuse disorders, and made the point that in this way Montana's justice system serves as a de facto behavioral health system. Interviewees also noted the high cost of incarceration for individuals with behavioral health concerns as a potential justification for considering justice system reforms—such as implementing effective jail diversion programs—to help individuals access treatment and to prevent recidivism.

Another point of entry into the behavioral health system is the public school system. Montana has invested heavily in mental health treatment in schools. For instance, the Montana Medicaid program embeds mental health therapists and behavioral aides in Montana schools through the Comprehensive School and Community Treatment (CSCT) program, which provides medically necessary therapeutic and behavioral intervention to more than 6,400 youth at a total cost of $32.2 million in fiscal year 2015.[38] This represents 27.0% of the overall children's mental health treatment budget through DPHHS. School counseling and psychology services also serve thousands of public school students and are an important point of entry into the system for many youth, including those who are not on Medicaid.

Summary: Challenges in the Current Public Behavioral Health System in Montana

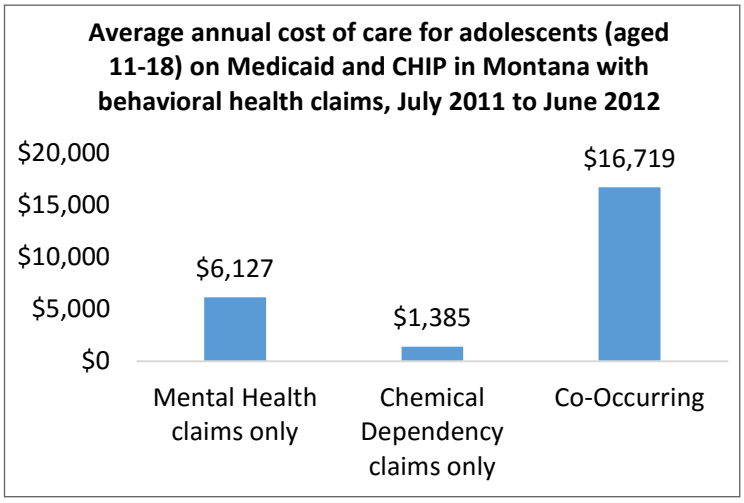
Montana's current behavioral health system is fragmented, with separate administration, funding, and service provision for mental illness and substance abuse disorders. The separate administrative and payment systems for these is also a barrier to implementing an integrated behavioral health system in which patients can receive primary care, mental health services, and substance abuse disorder services in a coordinated, cohesive manner. As a result, individuals with complex and often interconnected medical, mental health, and substance abuse concerns must often receive care through multiple separate agencies, oftentimes through the criminal justice system or in schools, which may not be equipped to provide comprehensive care. Given the strong evidence that integrated behavioral healthcare can improve health outcomes and reduce associated costs, this fragmentation may constitute an important missed opportunity to improve the value of Montana's public system of care.

The Private Mental Health and Substance Abuse Disorder Treatment System

Though the public mental healthcare system covers thousands of low-income children and adults with behavioral health concerns, many individuals have private or commercial insurance. For those with insurance, the Affordable Care Act has provided one of the largest expansions of mental health and substance abuse disorder coverage in recent history, requiring that most individual and small employer health insurance plans (including all plans offered through the Health Insurance Marketplace) cover mental health and substance abuse disorder services. Also required are rehabilitative and habilitative services that can help support people with behavioral health challenges. These new protections build on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provisions to expand mental health and substance abuse disorder benefits and federal parity protections to an estimated 62 million Americans. Because of the law, most health plans must now cover preventive services, like depression screening for adults and behavioral assessments for children, at no additional cost. And, as of 2014, most plans cannot deny coverage or charge clients more due to pre-existing health conditions, including mental illnesses.[39]

These newly covered services and the population of people now becoming insured under the program provide an opportunity to capitalize on the demand for and reimbursement of more robust, evidence-based behavioral health services.

Despite these coverage protections, patients with private insurance can still face high co-pays and deductibles that affect their willingness to accept treatment. Behavioral health issues, particularly complex cases like co-occurring mental health and substance use disorders, are expensive to treat. A 2012 analysis found that the average annual cost for an adolescent client with co-occurring mental illness and substance abuse disorder (SUD) in Montana on Medicaid was $16,719 per year, over 270.0% higher than those clients with only a mental illness diagnosis ($6,127) and 1,200.0% higher than the average cost for a client with only a chemical dependency diagnosis ($1,382). Though these numbers reflect the



costs of care for clients covered by public programs, the costs for individuals with private insurance, who must shoulder at least a portion of the total costs through co-pays and deductibles, are likely similar, if not higher. For families with private insurance, and especially clients who are underinsured or uninsured, these costs can be prohibitive.

Montana's Behavioral Health Workforce

Even patients with excellent private insurance may find it difficult to access behavioral health services in many parts of the state because of the shortage of providers in the behavioral health workforce. All Montana counties, except for Yellowstone County (Montana's largest), are designated as Healthcare Professional Shortage Areas for Mental Health.[40] In fact, the Henry J. Kaiser Family Foundation estimates that only 25.0% of Montana's mental health care professional need is met, placing it in the bottom five of all states.[41] Though the shortage of providers is statewide, rural and frontier communities often suffer the most from a lack of licensed providers. Montana's population is largely concentrated in six urban counties, while the remaining 50 counties are classified as rural or frontier, with 22 of the 56 total counties having fewer than 5,000 residents. The populations in these regions are spread out over large areas and often located hundreds of miles from the nearest treatment centers and providers. The lack of access to services for substance abuse, mental health, and co-occurring disorder treatment in frontier and rural communities is well documented. A 2012 study found that residents in 19 Montana counties (34.0%) have three or fewer licensed professional categories available to them (*e.g.*, social workers, addiction counselors, psychologists, clinical professional counselors, pharmacists, and medical doctors). The report also found that 80.0% of licensed psychologists are located in only six counties which constitute 60.0% of the state's population, and that 78.0% of social workers, clinical professional counselors, and addiction counselors are located in just eight counties which constitute 65.0% of the state's population.[42] In all, 78.0% of Montana's behavioral health workforce resides in just eight counties[43]. In addition, 10 Montana counties have no state-approved substance abuse treatment program.[44] The majority of Montana's urban counties are located on the western side of the state, leaving individuals with behavioral health needs in eastern Montana few, if any, options to receive treatment within their own communities. The analysis conducted for the Montana Co-Occurring Capacity Building (MCCB) SAMHSA grant also notes that the counties in and around Indian reservations are often devoid of practicing behavioral health specialists.[45]

The table below describes the number and types of licensed behavioral healthcare providers in Montana, and details the number of counties that do not have any licensed providers.

Figure 2. Licensed Behavioral Health Providers in Montana

Type of Provider	Total Number in MT	Counties with None Practicing
Licensed Addiction Counselors	599	18
Licensed Clinical Professional Counselors	1074	13
Licensed Clinical Social Workers	708	15
Licensed Marriage and Family Therapists*	124	33
Dual Licensed (LAC plus mental health)	194	31
Licensed Clinical Psychologists	214	31
Psychiactric Nurse Practitioners	58	40
Psychiatrists	88	40

*Note: Licensed Marriage and Family Therapists are not reimbursed by Medicaid

Montana also suffers from a lack of professionals licensed to provide both mental health and SUD treatment, and the absence of a coordinated, statewide infrastructure to provide training to existing professionals. As the table above indicates, there are only 194 dually licensed providers in Montana (LAC + LCSW, LCPC or LMFT).

In numerous structured interviews, stakeholders also raised the concern of the lack of prescribers for psychiatric medications in the state. The number of licensed psychiatric nurse practitioners who have a current Montana address is 58 (practicing in only 16 of the 40 counties in the state) and there are currently only 88 licensed psychiatrists in Montana, 71 of whom practice in the five largest counties (Yellowstone, Missoula, Gallatin, Lewis and Clark, and Flathead).[47] The Henry J. Kaiser Family Foundation estimates that Montana would need an additional 27 psychiatrists to cover 100.0% of the mental health need in the state.[48] Only two licensed psychiatrists and two psychiatric nurse practitioners are located in counties east of Billings. Even in Yellowstone County (the only county not designated as Healthcare Professional Shortage Areas for Mental Health by HRSA), CEO of Riverstone Health John Felton reports that the wait to see a psychiatrist for patients referred to the community mental health center is between six and nine months.

Several providers noted the need to increase the number of prescribers in the state, perhaps through developing a psychiatric residency program at one of the large health systems in Billings or through the development of more psychiatric nurse practitioners, especially through the MSU School of Nursing. Utilizing tele-psychiatry was

also recommended by interviewees as a method to better utilize the existing prescribers in Montana. In addition to tele-psychiatry, a key component with many integrated behavioral health practices in the United States is psychiatric consultation. Psychiatric consultation utilizes the psychiatric provider in a consultative role to the primary care team with a clear scope of care and referral guidelines to psychiatric treatment.

Why Integration?

Imagine a typical patient seeking healthcare in Montana. This patient, whom we'll call Linda, might have a number of complex physical and behavioral health concerns. Regardless of where Linda begins her healthcare journey, be it at a primary care practice, community health center, or substance abuse provider, the current system in Montana will require that she seek care in a number of different locations, with entirely different systems for care provision and payment. On the following page is an illustration of what Linda's journey through the current healthcare system in Montana might look like, followed by a hypothetical comparison of what her healthcare experience might look like in an integrated setting.

As the below infographic indicates, an integrated system is much simpler for patients to navigate, creating a "no wrong door" approach that allows individuals with complex health needs to be served in one location, using a team of providers. The case for integration goes beyond simply making it easier for a patient to navigate the system, however. In rigorous, nationwide research, integrated models have repeatedly been shown to improve patient outcomes and reduce costs:

- A 2012 Cochrane Database Review of Randomized Control Trials, assessing the effectiveness of collaborative care for patients with depression and anxiety, found significantly greater improvement in depression and anxiety outcomes for adults treated using a collaborative care model in the short-term.[49]
- A 2015 Journal of the American Medical Association published a meta-analysis of randomized control trials, comparing outcomes experienced by children and youth in integrated medical-behavioral healthcare settings compared to standard care in the primary care setting. The study found that integrated care interventions resulted in significantly better behavioral health outcomes overall, particularly for children with an existing mental health diagnosis.[50]
- In the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) study, patients in the primary care setting with access to depression care managers had 12.1% lower total health care costs during a four-year period than patients with usual care.[51]
- A 2014 study on the economic impact of medical-behavioral healthcare prepared for the American Psychiatric Association found that between $26.3 and $48.3 billion could be saved annually in the public and private healthcare system in the U.S. if effective Integrated Behavioral Health systems were implemented nationwide.
- A 2015 analysis by the think tank The Third Way estimates a potential healthcare savings of $207 billion over 10 years in the U.S. healthcare system with widespread adoption of integrated models.[52]
- A recent meta-analysis and cost benefit analysis conducted by the Washington State Institute for Public Policy found that collaborative care can reduce mental health symptoms, particularly among depressed patients who also have primary healthcare concerns, and that the benefits of collaborative care exceed the costs. The estimated benefit to cost ratio for collaborative care was estimated at $5.31 ($5.31 of benefit to tax payers and participants is achieved for every $1 spent on collaborative care).[53]

Navigating the Healthcare System in Montana: Patient Profile

Current Model

Linda

Age: 42

Healthprofile

- Diabetic
- Stressful, retail job
- Trouble getting up in the morning
- Drinks 3-4 alcoholic beverages/day
- Insurance: Medicaid

Linda has been worried about her blood sugar and stress at work. She goes to visit her doctor.

Primary Care Clinic

Looking at Linda's intake assessment, the doctor notices that Linda is showing signs of depression. He suggests she schedule an appointment with a therapist at the Community Mental Health Center.

Community Mental Health Center

After a 5 week wait, Linda sees a therapist who assesses her alcohol intake and suggest she see a Licensed Addiction Counselor at the state certified Substance Use Provider in her county.

Community Substance Use Provider

Linda is seen by a Licensed Addiction Counselor for several months for her alcohol use but she finds it difficult to change her behavior. She still has trouble getting out of bed and continues to feel overwhelmed by her job and the demands of managing her diabetes. She bounces back and forth between all of her providers, none of whom share information on her care, and has had several ER visits this year.

Integrated Behavioral Health Model

Linda has been worried about her blood sugar and stress at work. She goes to visit her doctor.

Linda begins to feel confident about taking control of her own health. She attends regular appointments at the Integrated Behavioral Health Clinic and calls her case manager when she is feeling ovehwelmed or has questions. Linda knows she can go to the clinic for all of her healthcare needs.

During Linda's intake, the nurse gives Linda an evidence-based assessment for her physical and mental health and substance use behaviors. Concerns related to alcohol, depression and uncontrolled diabetes are flagged.

Integrated Behavioral Health Clinic

Because Linda's depression is worsening, her care team calls the clinic's offsite Psychiatric consultant, who advises them on a course of action for Linda's treatment. Linda leaves the clinic with a new anti-depressant presariptionand the care manager follows up by phone for the next week.

For the next few weeks the care manager follows up with Linda by phone to discuss her health. Linda is successfully controlling her blood sugar and is reducing her alcohol use but her mood continues to deteriorate. The care manager consults with the team and schedules an appointment for Linda to come back into the clinic.

Linda's primary care provider reviews her assessment and provides recommendations for her treatment. She asks if Linda would be willing to talk to the behavioral health specialist on staff today about her depression and alcohol use. Linda agrees.

The Behavioral Health Specialist, a dually licensed social work and addiction counselor, talks with Linda about her healthcare needs and priorities. Together, they formulate a plan to begin to treat her depression and address her alcohol intake, diet and stress at work.

After the Linda leaves, the primary care provider, nurse and Behavioral Health Specialist meet with the clinic's care manager to formulate a team-based care plan for Linda. The care manager agrees to follow up with Linda later in the week.

Integrated Behavioral Healthcare models have been shown to be effective even in rural areas, especially when larger health systems provide support for training and consultation. A recent report for the Health Resources and Services Administration highlights a few examples.[54]

- The Cherokee Health Systems in Tennessee has developed an integrated biopsychosocial approach to healthcare. "At Cherokee Health Systems, behavioral health consultants are embedded members of the primary care team, providing real-time assessments, brief interventions with patients, and consultation with providers. The behavioral health consultants provide education, behavioral management, and intervention services for behavioral health and medical conditions. The director of psychiatry consults with primary care providers, rather than carrying his own caseload, and is able to do this consultation from off-site via video conference… The program, centered in Knoxville, Tennessee, is also reaching out to rural providers by serving as a training site for behavioral health professionals to gain hands-on experience in the integrated health model."[55]
- The Shenandoah Valley Medical System, an FQHC in rural West Virginia, is also a model of what integration can look like Montana. The FQHC provides behavioral health screening to all primary care patients annually, including post-partum screenings for new mothers, and follow-ups with on-site behavioral health consultation for any patients with flagged conditions. After the behavioral health consultation, if further assessment or treatment is warranted, the consultant registers the patient with the Behavioral Health Services department and they are seen for follow-up in the same building. The behavioral health consultant remains a member of the integrated primary care team for all patients seen at the clinic.[56]

These are just two examples of sites that are making integration a reality in rural communities, effectively reaching underserved populations with critical behavioral health services integrated in the primary care setting.

Based on the research highlighting the cost effectiveness and improved patient outcomes afforded by integrated models, it appears that Integrated Behavioral Health may offer a promising approach to addressing some of the challenges documented in this report.

Towards A More Integrated System: Initiatives in Montana

Recent Grants and Health System Work

In the past few years, a number of initiatives have begun to pilot and develop institutional support for Integrated Behavioral Health in Montana. These are briefly reviewed here.

The Montana Co-Occurring Capacity Building Project (MCCB)

This SAMHSA grant, which provided funding in Montana from 2012 to 2015, was designed to increase access to and the quality of treatment services for substance abuse and co-occurring mental health among Montana youth. Two sites, Western Montana Addiction Service in Missoula and Intermountain in Helena, were funded to pilot evidence-based treatment modalities that addressed the needs of co-occurring clients.

The grant also included the development of a Workforce Advisory Committee to map the clinical workforce in Montana, a survey of the co-occurring workforce to identify training needs, and online and in-person trainings to address identified needs. The project also led to the development of a baseline financial map to document state-managed expenditures for youth aged 12 through 17, who received a mental health service, a chemical dependency service, or both, through state fiscal year 2012. Though this project didn't specifically address the integration of primary care, it examined the need to integrate mental health and substance abuse disorder treatment.[57]

Project LAUNCH

Montana's *Project LAUNCH Initiative,* funded by SAMHSA in 2014, focuses on engaging early childhood partners across Montana to improve systems and access to mental health services for young children and families, while piloting evidence-based practices in Gallatin and Park Counties in southwestern Montana. The population of focus for the *Project LAUNCH Initiative* is pregnant women, children aged 0-8, and their families and caregivers. Several of the key initiatives being piloted through *Project LAUNCH* relate to behavioral health integration, including 1) universal screening using the Ages and Stages Questionnaire-3 (ASQ-3™) and Ages and Stages Questionnaire: Social Emotional (ASQ:SE), 2) integration of behavioral health into primary care settings, and 3) mental health consultation in early care and education. Jodi Daly, the CEO of the Western Montana Mental Health Center, reports that, through the *LAUNCH* grant, "Our Bozeman facility is placing therapists outside of our community mental health center campus. The therapists are working with kids in community-based settings and making sure that physicians have better access to behavioral health." The *LAUNCH* funding will continue until 2019.

State Youth Treatment and Implementation (SYT-I)

In 2015, Montana applied for and received three years of funding for State Youth Treatment-Implementation (SYT-I). This grant, like MCCB, seeks to increase access to evidence-based co-occurring treatment in Montana, with a focus on transitional-age youth, aged 16 to 25, with SUD and/or co-occurring substance abuse disorders and mental illness. The project provides funding to four provider sites, three in central Montana and one in eastern Montana, to implement the evidence-based practice Interactive Journaling, which is well-suited for use with the population of focus and with Native American clients. Interactive Journaling is a "goal-directed, client-centered model that aims to reduce substance abuse and substance-related behaviors, such as recidivism, by guiding adults and youth with substance abuse disorders through a process of written self-reflection."

More importantly, in terms of integrated systems, the four provider sites for SYT-I will also pilot a Behavioral Health Home model throughout the course of the project to provide more comprehensive behavioral health care to the transitional-aged youth being served. The four sites for this project are the Great Falls Center for Mental Health (Community Mental Health Center), Bullhook (FQHC) in Havre, the Rimrock Foundation (Community Mental Health Center and Substance Use Disorder Treatment Center) in Billings, and the Helena Indian Alliance (FQHC) in Helena. The behavioral health home sites will be required to have both licensed mental health and substance abuse providers operating and billing onsite, using evidence-based assessments and treatment. In addition, grant funds will be used to improve the infrastructure related to serving those with co-occurring illnesses and youth with substance abuse disorders in Montana, including bolstering workforce development for professionals, addressing policy and funding barriers, engaging youth and caregivers in designing systems, and implementing evidence-based care. By the end of the project, the State of Montana will submit a Behavioral Health Home State Plan Amendment to CMS to create sustainable systems for reimbursement of comprehensive treatment for substance abuse and mental health services treatment at a single facility.

Patient-Centered Medical Homes

Definition: "In Montana, a patient-centered medical home is health care directed by primary care providers offering family centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services."[58]

The Montana Patient Center Medical Home Act, passed in 2013, which gives Securities and Insurance Commissioner, in consultation with a 15-member Stakeholder Council, authority to set participation, reporting, and payment standards for providers and insurers. As a result of this Act, Montana announced the launch of a vol-

untary, statewide multi-payer patient-centered medical home (PCMH) initiative in March 2014. The initiative agreed to the above definition for PCMH in the state. The PCMH is led by the state's Commissioner of Securities and Insurance and includes participation by Montana Medicaid and three commercial health plans: Allegiance Benefit Plan Management, Inc.; Blue Cross Blue Shield of Montana; and PacificSource Health Plans. According to the initiative's 2015 public report, 100 practices in the state have been certified as PCMHs and 81 practices have been provisionally certified as PCMHs.[59]

The original set of metrics adopted for use in 2014 PCMHs focus primarily on chronic disease management, but the tobacco cessation metric description does mention the use of behavioral health professionals:

> METRIC 3: Tobacco Screening and Cessation Intervention: A team-based approach to improve patient tracking incorporating behavioral health prevents tobacco users from being overlooked because it is a comprehensive approach.

After input from stakeholders in 2015, the PCMH Stakeholder Council recommended that the Commissioner add one additional quality metric, depression screening, for the 2016 reporting year, which will increase the behavioral health requirements in certified PCMHs in the state.[60] This effort is still at an early stage, and does not yet address the more complex needs of individuals with SDMI or SED, but it holds promise as a statewide initiative, coordinating payment reform and focusing on quality care.

Centers for Medicare and Medicaid Services State Innovation Model Grant

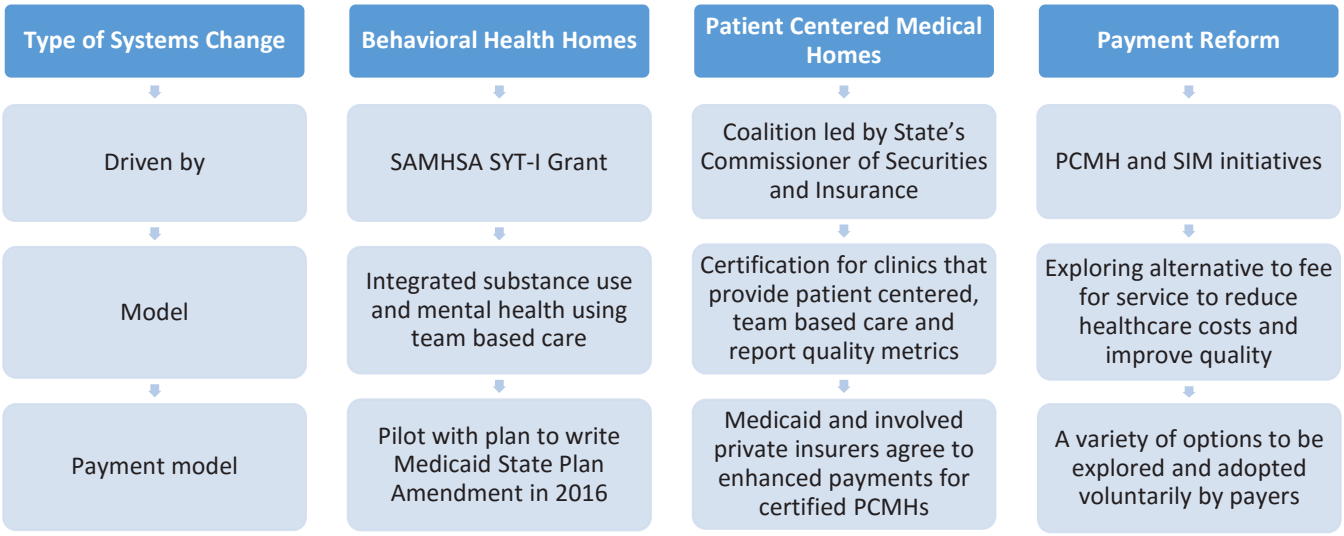
In May 2015, Montana was awarded a one-year State Innovation Model (SIM) grant by the Centers for Medicare and Medicaid Innovation initiative. The grant brings together key stakeholders across the state to design a State Health Care Innovation Plan focused on supporting multi-payer and system transformation. To guide the planning process, Montana has convened a Governor's Council on Healthcare Innovation and Reform that includes representatives from private and public payers, as well as a variety of other stakeholders to identify opportunities to better coordinate care and build efficiencies into Montana's healthcare system. The Governor's Council has identified three key priorities to address as part of this planning process, including:

- Behavioral and physical health integration, including substance abuse/chemical dependency and mental health
- Disparities and social determinants of health
- Health information exchange and telehealth

Ultimately, the goal of the SIM grant is to increase the value of healthcare in Montana by reducing costs and increasing the quality of care. Payment reform and innovation in terms of healthcare reimbursement will be one of the primary drivers of this initiative, which DPHHS hopes to continue beyond the one-year funding period.

The following table summarizes the important healthcare systems changes mentioned above currently occurring in tandem.

Healthcare Systems Change Initiatives in Montana



Montana Healthcare Foundation 2015 Grants Related to Integrated Behavioral Health

In addition to the existing grants and initiatives related to integration supported by the State of Montana in 2015, the Montana Healthcare Foundation awarded a number of grants to partners at the local level to pilot projects related to healthcare integration and support training and workforce development work for healthcare professionals. A summary of Montana Healthcare Foundation awards to local agencies in 2015 Montana specifically related to Integrated Behavioral Health can be found at http://www.mthcf.org/2015/11/new-2015-grantee-descriptions/.

National Integrated Behavioral Health Initiatives

This section reviews several national resources and case examples related to implementing Integrated Behavioral Health.

The SAMHSA-HRSA Center for Integrated Health Solutions

The SAMHSA-HRSA Center for Integrated Health Solutions, run by the National Council for Behavioral Health (a Washington D.C.-based non-profit organization), supports providers nationwide who wish to integrate primary care and behavioral health services. This facility provides training and technical assistance to more than 168 grantees that receive SAMHSA Primary and Behavioral Health Care Integration grants, along with other resources that are transitioning to a more integrated model. The Center has expertise training organizations to create Behavioral Health Homes and Certified Behavioral Health Centers.

For more information about the National Council for Behavioral Health, visit: thenationalcouncil.org. For more information about The SAMHSA-HRSA Center for Integrated Health Solutions, visit: integration.samhsa.gov

Center for Integrated Care at the University of Massachusetts

The Center for Integrated Care at the University of Massachusetts provides training and technical assistance to healthcare organizations that are seeking to integrate their services. The two main services provided through

The Center for Integrated Primary Care are training for healthcare providers and evaluation support. These activities are reflected in the Center's mission which is to develop, synthesize, and disseminate skills for best practices in Integrated Primary Care (IPC) so as to become a national leader in workforce development, and to serve as a center of excellence in the evaluation of integrated programs. The Center has developed web-based training programs for providers and healthcare administrators at all levels to help prepare them to successfully transition their organizations to integrated behavioral healthcare models. They also consult nationwide with initiatives that are seeking to measure and evaluate the results of their integration efforts.

For more information about the Center for Integrated Care at the University of Massachusetts, visit: www.umassmed.edu/cipc

The Academy for Integrating Behavioral Health and Primary Care

In recent years, as the behavioral health integration model has become more prevalent, the demand has increased to collect, analyze, synthesize, and issue actionable information that providers, policymakers, investigators, and consumers can readily use and apply. The Agency for Healthcare Research and Quality's (AHRQ) Academy for the Integration of Behavioral Health and Primary Care is designed to meet this need. The Academy's website includes a database for the research into Integrated Behavioral Health and information on how to effectively implement Integrated Behavioral Health practices on a meaningful scale. In additional to compiling research findings, the Academy is designed to function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare. The AHRQ Academy web portal offers a repository of resources to advance the integration of behavioral health and primary care, and fosters a collaborative environment for dialogue and discussion among relevant behavioral health leaders.

To learn more about the Academy for Integrating Behavioral Health and Primary Care, visit: www.integrationacademy.ahrq.gov/

The Maine Integrated Health Initiative

This multi-year statewide integrated behavioral health project, led by the Maine Health Access Foundation, successfully supported a systems-level integrated behavioral healthcare transformation process in a rural state. In 2005, the Maine Health Access Foundation began bringing together key stakeholders to discuss what IPC in the state of Maine should look like. The Foundation convened stakeholders who discussed and agreed upon definitions for Integrated Behavioral Healthcare. Stakeholders also outlined specific steps to move toward integration. After agreeing on definitions, the Maine Health Access Foundation conducted a series of focus groups and other interviews, engaging nearly 2,000 additional community members and interested partners. They found there was overwhelming support for a more integrated, team-based approach to healthcare.

In 2007, the Foundation started an IBH initiative designed to encourage providers to integrate mental health and primary care. They provided implementation grants up to $325,000 total for three years and planning grants up to $60,000 total for three years. During the implementation phase, providers were expected to hire integrated staff and developed integrated systems. The Foundation also developed a systems transformation grant which focused on state-level policy and systems work to bring the integration lens to bear on these initiatives. As a result of these efforts, the Maine Department of Health and Human Services included IBH as a primary requirement for certified Primary Care Medical Homes and Behavioral Health Homes. Integrated care was also written into the State Innovation Model (SIM) grant. In addition, Maine's Medicaid program (Maine CARE) opened its billing codes, allowing FQHCs to bill for behavioral health services and community mental health centers to bill for primary care services. Several private payers followed suit, incentivizing providers to bring on integrated staff that could now be supported through third party reimbursement. Currently, at least 50.0% of the primary care providers in Maine have some level of integrated behavioral healthcare, largely as a result of this statewide initiative. The Main Integrated Health Initiative is an excellent example of statewide systems change initiative, led by a

healthcare foundation, which supported real and sustained IBH systems transformation.

For more information on the Maine Integrated Health Initiative, visit: www.mehaf.org/

There are several other successfully, high-level state and national efforts related to IBH. Some examples include:

- ***The Collaborative Family Healthcare Association:*** The CFHA is national organization advocating for comprehensive and cost-effective healthcare delivery models that integrate mind and body and involve patients, families, and communities. www.cfha.net
- ***Missouri's Behavioral Healthcare Homes Initiative:*** Supported by the Missouri Coalition for Community Behavioral Healthcare, this initiative seeks to support the implementation of behavioral health homes across the state that provide equitable, comprehensive, and integrated care. http://www.mocoalition.org/#!health-homes/c14fu
- ***Colorado Behavioral Healthcare Council:*** This statewide membership organization for community behavioral health providers contracts with the state of Colorado to support comprehensive behavioral health and psychiatric services in every region of the state. CBHC provides a network of skilled therapeutic and community resources to meet the behavioral health needs of all Colorado residents and their families so that all can have equal and full access to a quality of life. www.cbhc.org
- ***AIMS Center at the University of Washington:*** The University of Washington's AIMS Center develops, tests, and helps implement collaborative care models in healthcare facilities around the country. They provide coaching and implementation support, research collaborations, and education and workforce development. www.impact-uw.org
- ***The Eugene S. Farley, Jr. Health Policy Center:*** Affiliated with the University Of Colorado Department Of Family Medicine, the Farley Policy Center houses a team of clinicians, evaluators, and integration advocates who provide support to primary care and behavioral health organizations nationwide who desire to transform into integrated, collaborative settings. http://farleyhealthpolicycenter.org/

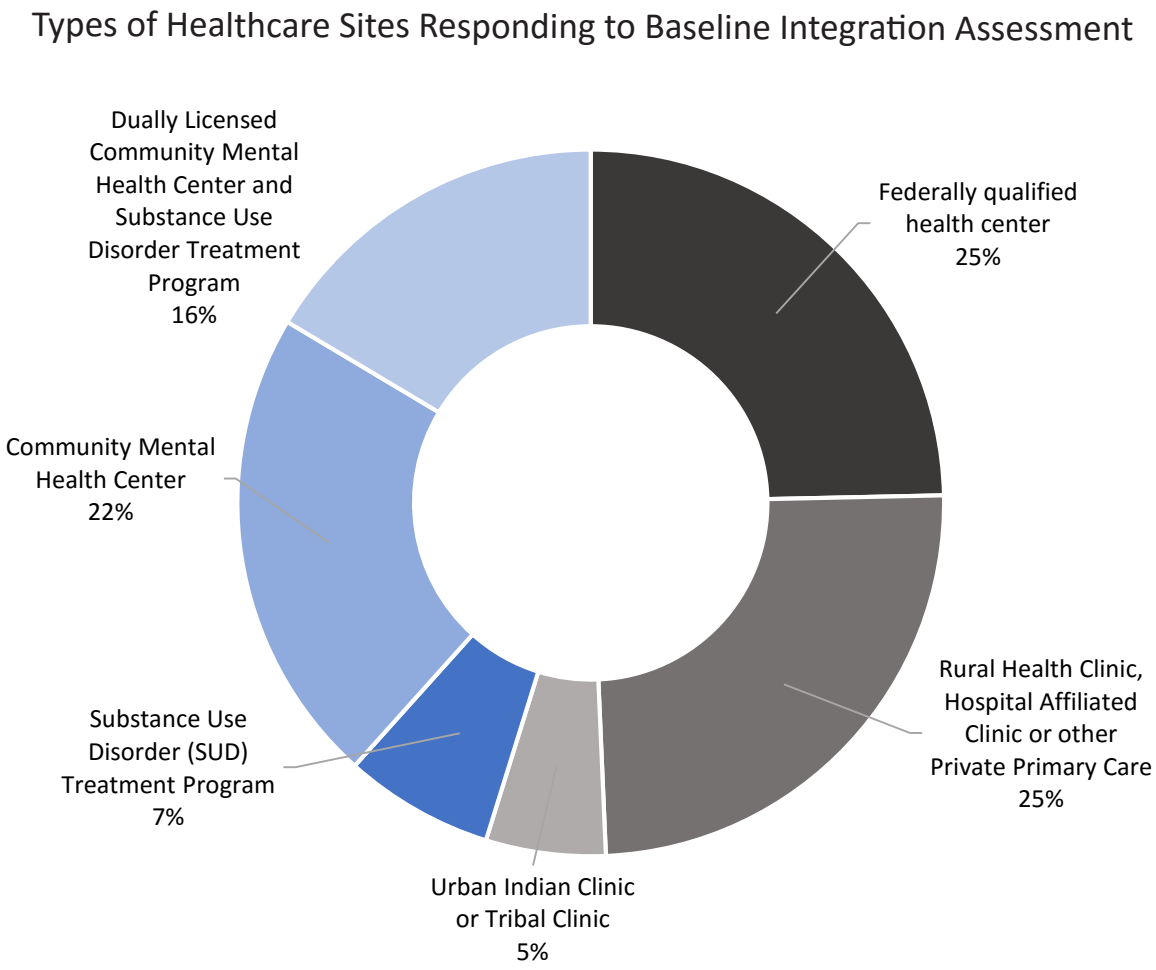
Integration in Montana

Results of the Integrated Behavioral Health Baseline Assessment

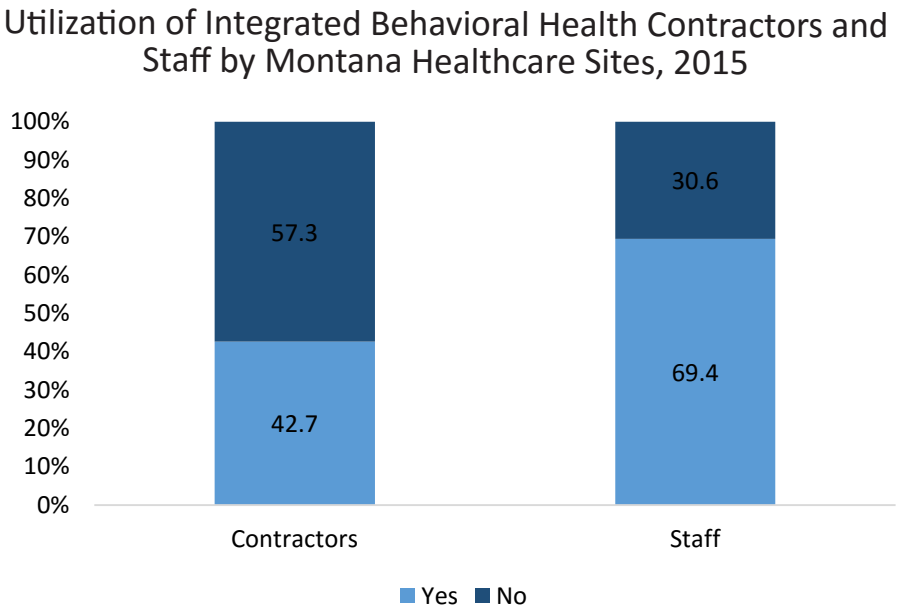
As part of this baseline assessment project, healthcare provider sites in Montana were surveyed electronically to assess their current levels of integration. In October 2015, an electronic baseline assessment survey tool was sent to all community mental health centers, substance abuse disorder treatment programs, FQHCs, urban Indian clinics, and tribal health department contacts in Montana. In addition, the Montana Hospital Association distributed the survey tool to all hospitals in the state to send on to their affiliated primary care clinics in order to reach at least one subset of private primary healthcare providers. Below are the results of this assessment. It should be noted that this survey data is not weighted and is not representative of all providers in the state, particularly independently owned practices which were not included in the distribution plan. Also, there may well be a response bias in these findings toward providers who are interested in or already are implementing integrated models, as the providers who are already engaged in integration may be more likely to respond to a survey on the topic.

In all, 73 healthcare provider sites responded to the survey. Fifty percent of the sites who responded were primary care sites: either FQHCs, rural health clinics, or hospital or university affiliated clinics. Forty-five percent were behavioral health sites, community mental health centers, substance abuse disorder treatment programs, or dually licensed providers, and 5.0% were urban Indian health or tribal clinics. Because of the low response

rate from urban Indian health and tribal clinics, and because we were not granted permission to survey the Veteran's Administration clinics in the state, the level of integration within these important healthcare systems will be the topic of further study in the future. The survey instructions sent to sites asked that the tool be filled out by a member of the senior staff with in-depth knowledge of the staffing and operations at the clinic. Ninety percent of the respondents who filled out the survey indicated their job title was administrative: either CEO, CFO, executive director, clinic manager, or medical director. The remaining 10.0% of respondents were health-care providers serving onsite at the clinic.



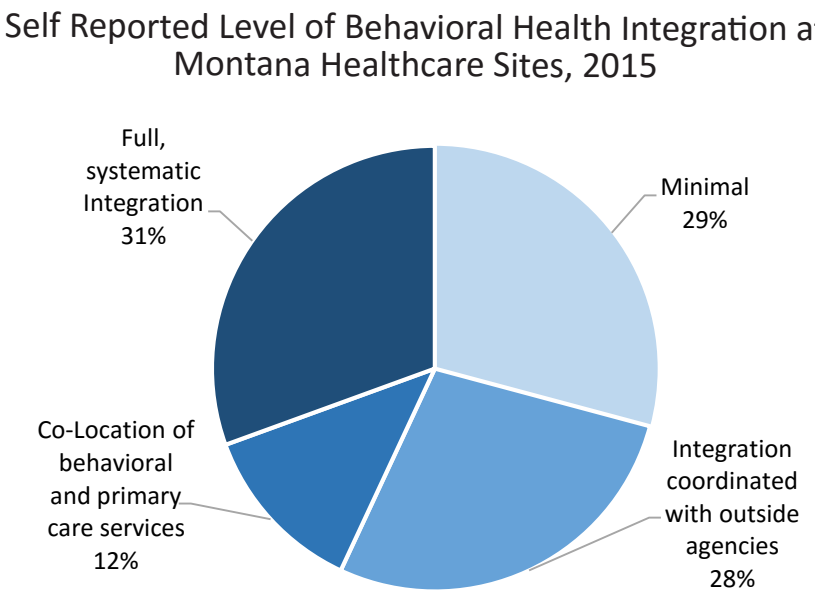
The majority of the responding healthcare sites indicated that they have some level of staffing available to do integrated work. Forty-two percent of sites reported having contract integration staff and 69.0% indicated that they have at least one provider on staff specifically related to integration. The provider sites with the least level of integration were community mental health centers, with 42.0% indicating that they did not have any integrated professionals on staff (either LACs or primary care providers).



Sites were asked to rate the overall level of integration at their facility. The choices sites were given to rate their overall level of integration included:

- Minimal. Consumers go to separate sites for services and we do not currently coordinate behavioral health and primary care services except through referrals. We do not contract with or employ any mental health or substance use professionals.
- Service are coordinated through formal agreements with other organizations that provide additional services, but we have separate sites and systems. There is ongoing communication between our organizations and the different types of providers. We actively refer clients to services we do not provide.
- Services are co-located. Both primary care and behavioral health services are available at the same site but the systems are separated (no shared reception area or joint appointment scheduling). There is regular communication among different types of providers and some coordination of appointments and services.
- Primary care and behavioral health services are integrated with one reception area and appointments are jointly scheduled. We share sites and systems including electronic health record and shared treatment plans. Warm hand-offs occur regularly and there are regular team meetings.

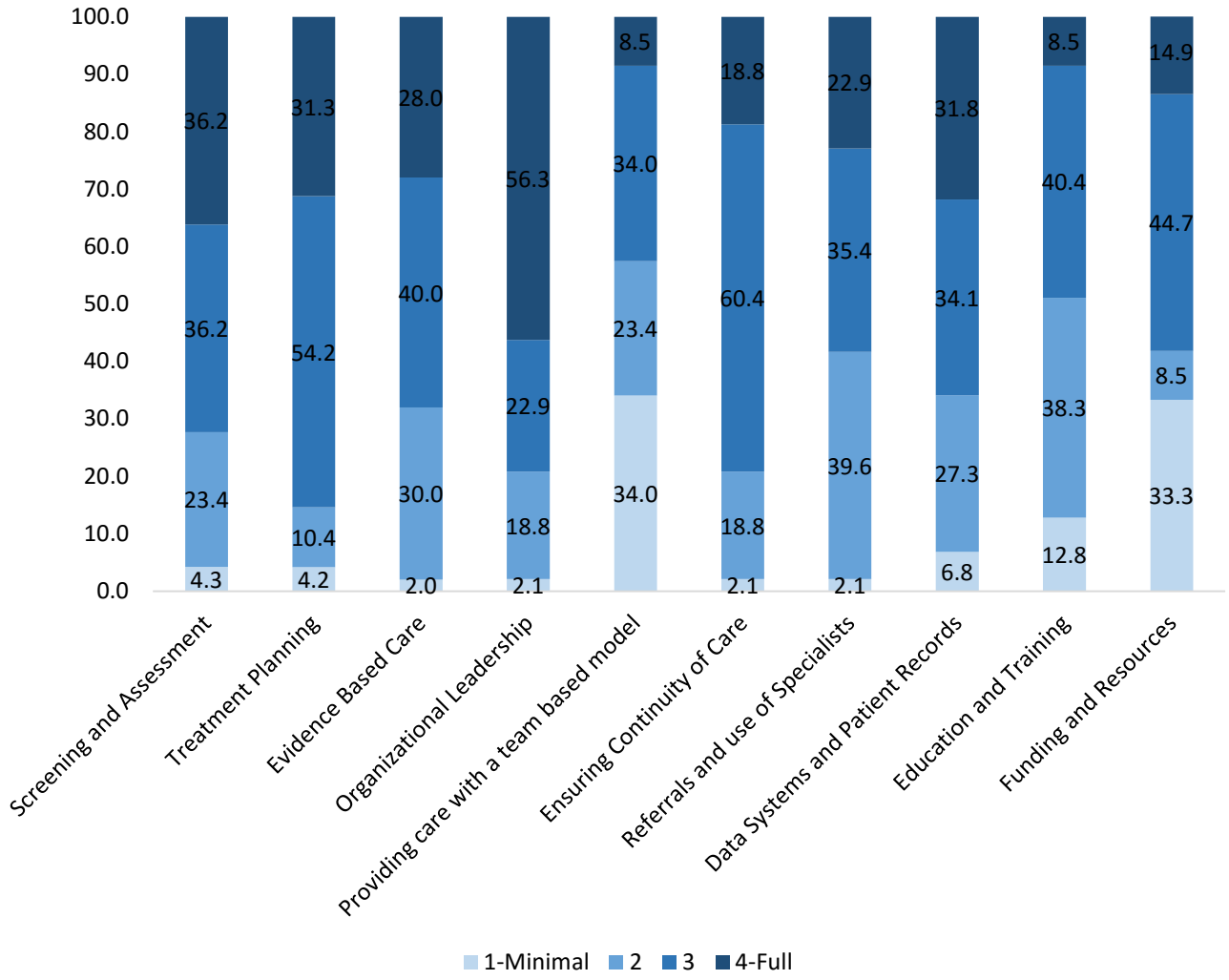
Almost one third of responding sites indicated that integration at their site is minimal with no integrated professionals on staff, consumers going to separate sites for services, and no coordination of behavioral health and primary care services except through referrals. However, almost one third of responding providers indicated that their services are fully and systematically integrated, with primary care and behavioral health services accessed through one reception area and appointments scheduled jointly. These sites indicated that they share sites and systems, including electronic health records and shared treatment plans, that warm hand-offs occur regularly, and there are regular team meetings. Another 40.0% of providers fell somewhere in the middle of these two extremes. There were major differences between the types of sites and their indicated levels of integration. All but one responding FQHC indicated full integration (94.0%). Conversely, no substance abuse disorder treatment programs and only one community mental health center indicated full integration. Hospital-affiliated primary care clinics were more of a mix, with 44.0% indicating minimal integration and 16.0% indicating full integration.



As indicated in the introduction to this paper, fully Integrated Behavioral Health models are characterized by a range of specific services, including team-based care, integrated treatment planning, the use of evidence-based practices, and a clear system for referrals, follow-up, data sharing, and training. The 50 responding healthcare sites that indicated that they have some level of integration were asked to rate their use of a number of these key integrated elements in their day-to-day practices.

These findings indicate that Montana providers who are currently implementing integrated systems often have the support of organizational leadership, but could use technical assistance in a number of key areas, including implementing team-based care models, ensuring continuity of care and follow-up for patients, education and training for staff, and funding and resources specifically for IBH. Thus, even among clinics that have started moving toward integrating systems, this process is still in the early phase of development in Montana.

The Level of Behavioral Health Integration for Key Clinical Processes among Montana Healthcare Sites, 2015



Examples of Integrated Behavioral Health in Montana

This section presents examples of Montana healthcare organizations that are pioneering the use of IBH according to best practice guidelines and models.

Bighorn Valley Health Center

Bighorn Valley Health Center is an FQHC with sites in Hardin and Ashland (rural communities in southeastern Montana) that has been in operation for just three years. Dr. David Mark, the chief executive officer of the Bighorn Valley Health Center, notes that, “From the very beginning, we understood that we couldn’t accomplish our mission until we were integrating behavioral health into primary care.” The board made behavioral health a key priority and hired a medical director who is a medical psychologist, a unique decision for an FQHC, which follows a model that has traditionally focused on primary care. Dr. Mark explains, “We intentionally wanted a behavioral health provider to be our medical director to emphasize the point that behavioral health issues are

so fundamental to what we are trying to do." Early on, the Center also applied for and received funding from the John A. Hartford Foundation to implement the evidence-based IMPACT model, which focuses on screening and team-based care for depression. The model allowed them to adopt a universal depression screening for all patients aged 12 and older, and to refer any identified patients to treatment using a patient-centered, team-based approach in which the primary care provider conducts a brief intervention with the patient and then facilitates a warm hand-off to the Behavioral Healthcare Manager. The Behavioral Healthcare Manager, who coordinates the treatment plan for the patient and advocates for their behavioral health needs, has proved to be a vital part of the IBH approach at this site, but funding the position is a challenge in the absence of grant funding. The Center also engages a psychiatry consultant using the telehealth company Health Link Now for patients who require a higher level of care. Dr. Mark notes that while the IMPACT model is primarily focused on depression, they have "really been able to use the mechanics of that approach to try to tackle a full range of behavioral health issues."

For more information on the Bighorn Valley Health Center, visit: www.bighornvalley.org

Community Health Partners

Community Health Partners is also an FQHC, with medical and dental clinics in several communities in south-central Montana, including Bozeman, Belgrade, Livingston, and West Yellowstone. Annually, providers at Community Health Partners have over 45,000 patient encounters with a largely low-income population. Fifty-five percent of Community Health Partner's patient population is uninsured and 95.0% are below 200.0% of the Federal Poverty Level. In recent years, Community Health Partners has hired onsite behavioral health practitioners (LCPCs or LCSWs) at all of its clinics, ensuring that these have full time behavioral health coverage at their sites in Livingston, Bozeman, and Belgrade. The behavioral health staff offer counseling to patients who are established in the medical clinics. Behavioral health consultations are available through warm hand-offs from the primary care providers for patients who need to be seen immediately for crisis intervention. The behavioral healthcare providers have also begun to offer group therapy for chronic pain and dialectical behavioral therapy (DBT), which is used to treat a range of mental health and substance abuse concerns. They also facilitate parenting support groups. Lander Cooney, the executive director of Community Health Partners, describes her organization's approach to integration this way: "We seek to provide behavioral health services inside our walls and make accessing these services seamless. All of our clients have the same waiting room and their care is tracked using the same electronic health record. And to ensure that all patients are receiving primary care, we require that each patient be established with our primary care team before they access behavioral health services."

To further develop a fully integrated model, Community Health Partners has piloted a project embedding a behavioral health graduate student in the primary care treatment team (instead of having behavioral health professionals as in-clinic referrals). However, funding this position long-term has proven difficult. Integration has also been accomplished through agreements with community mental health centers. At the Gallatin Mental Health Center, Community Health Partner's West Yellowstone clinic, a counselor is provided one day a week to serve clients.

For more information about Community Health Partners, visit: www.chphealthmt.org

Leo Pocha Memorial Clinic at the Helena Indian Alliance

The Leo Pocha Memorial Clinic is an Urban Indian Health Center in Helena, Montana, that carries an Indian Health Service contract to provide health services to American Indians. The clinic is also an FQHC that is committed to providing health services to all patients seeking services, regardless of race or insurance status. In the last year, the clinic received its certification as an SUD treatment program. The clinic is staffed by two primary care providers (Nurse Practitioner and Physician), three LACs who staff the substance abuse program, and three mental health providers (an LCSW, an LCPC, and Psychiatrist). The Leo Pocha Memorial clinic is one of the few sites in Montana in which licensed mental health, substance abuse disorder providers, and primary care provid-

ers all operate out of the same facility. Tressie White, an administrator at the clinic, explains the clinic's treatment procedure: "When a patient comes to us, we require them to see a medical provider first for screening and assessment for depression, alcohol and substance abuse, and domestic violence in addition to their primary care assessment. Based on the assessment results, our medical provider will make the proper referral to mental health and chemical dependency. We see a lot of people with co-occurring diagnoses. So the medical provider can make the referrals needed. Our electronic health record is integrated with mental health, substance abuse, and primary care all on the same system." This model of care has been in operation at the Leo Pocha Memorial clinic for many years, though the program has grown drastically over the last few years. The clinic is currently looking into providing dental care onsite and expanding its case management services for the most complex behavioral health patients.

For more information on the Leo Pocha Memorial Clinic, visit: www.helenaindianalliance.com

Winds of Change Mental Health Center

Located in Missoula, the Winds of Change Mental Health center seeks to integrate primary care services into the community-based care they provide to adults with serious and disabling mental illness and children with serious emotional disturbances. The community mental health centers operated by Winds of Change employ three nurse practitioners. All clients come into one reception area and all clients receive assessments for mental health, as well basic assessments for primary care and substance abuse. The center provides care for each client under a treatment plan that covers both mental health and physical health needs. Substance abuse disorder clients are referred out because Winds of Change does not have LACs on staff. Dan Ladd, CEO of Winds of Change, describes the systems of care that are being developed in his agency: "We want to have a one-stop shop where the client isn't running around the different offices for different kinds of healthcare. We are trying to foster a system where providers are talking to each other within our agency. And we work hard to coordinate with corrections, substance abuse providers, Western Montana Mental Health Center, which provides crisis services, and other entities in our community."

Survey Respondent Views on the Benefits of Integration

In both semi-structured interviews and the online survey tool, providers outlined the many benefits to patients that occur when behavioral health and primary care services are more integrated.

Provider satisfaction: Several clinic administrators described how team-based care that allows providers to truly address patient needs, be they physical or behavioral, is more satisfying for providers. Lander Cooney from Community Health Partners put it this way: "It's a huge support to our medical providers. There is nothing worse for a community health center physician than to have to tell a patient, 'Sorry there is nothing we can do for you.'" She also noted that having trained mental health staff on their team makes her primary care providers feel more confident and at less risk in their jobs. "The fact that we have reliable access to mental health professionals who can assess and de-escalate at any time is a huge help to our providers."

Raising awareness of and capacity to address behavioral health issues: Having behavioral health care providers embedded on a care team raises the awareness of the importance of behavioral health and its effect on overall health among team members. John Felton of Riverstone Health reflects, "I think one of the biggest benefits of integration is that, because we have behavioral health professionals in the clinic, there is a much higher awareness of behavioral health issues. All the time we are worried about your whole care. And with that awareness, we have done a much better job of intervening earlier. Getting people back under control earlier." Without the expertise in behavioral health, providers might make recommendations to clients to stop smoking, reduce alcohol use, or be more active, but without addressing the underlying behavioral health concerns, this advice does nothing to actually change patient behavior.

Improved Access: Montana has a well-documented shortage in behavioral healthcare access. Integrating behavioral health into primary care is one effective strategy to begin addressing this problem. One advocate called this model the "No Wrong Door" approach. If a client has a behavioral health concern and visits a primary care practice that follows an integrated model, then he or she is much more likely to receive effective behavioral health services, and to receive them onsite without needing a referral. The same is true for a SDMI client with physical health challenges who only seeks care at a community mental health center. If this site integrates primary care, then his or her chances of receiving appropriate primary care treatment greatly increases. Tressie White of the fully integrated Leo Pocha clinic says that, if primary care providers are screening all patients, then they will identify patients who are not even aware of their need for behavioral health services. She notes, "I would say access is just huge here. Sometimes the clients will see the medical provider, and they will be flagged as needing chemical dependency services, and then the LAC will recognize a need for mental health services." In a system that is able to assess and address all these patient needs, patients receive much better care without having to seek out providers in other locations.

Increasing Montana's ability to intervene early instead of during a behavioral health crisis: Increasing the number of primary care providers that are assessing and providing treatment for mental health issues may help avert some of the behavioral health crises faced by patients in Montana. Gary Mihelish of NAMI Montana describes how the current system is primarily tailored to respond to clients in crisis. "The treatment for people with serious mental illness is crisis-driven. I know families that have tried and tried to get their family members treatment. To access our mental health treatment system the only criteria is 'dangerous,' which means the person has to be a danger to themselves and others to get care. So we end up with tragedies because people can't access care earlier on. We have to find humane, compassionate ways to get people care." IBH systems that assess more clients with emerging behavioral health issues in the beginning stages of their illnesses may prevent more patients from decompensating to the place where they need crisis care.

Reduced Stigma: In Montana, seeking help for mental illness or substance abuse is often stigmatized, particularly in rural communities with few mental health or treatment facilities. Several primary care providers piloting integrated models noted that having integrated services helps reduce stigma, because clients can access care for their behavioral health problems in a primary care setting. One FQHC director put it this way: "They will come to our building because they need the care but it's not the mental health center. This breaks down that stigma. In the waiting room, no one knows if they are there for a flu shot or a counseling session. And it also shows patients that their mental health is healthcare."

Improved outcomes for patients: Joan King from the National Council for Behavioral Health summarizes the research on the effectiveness of IBH as follows: "The data is there to say that, when people receive services that are coordinated and take into account that these issues occur in the same body at the same time and that they impact the person, family, and community all at once, when care acknowledges this, then the care and outcomes improve." Providers utilizing integrated models in Montana attest to improved patient outcomes. Jodi Daly of Western Montana Mental Health Center describes how having primary care providers integrated into their community mental health center practices has helped several clients receive important diagnoses and access treatment. She notes, "Many of our clients don't have access to primary care providers; they go to the ER instead. So when we have primary care providers embedded in our mental health practice, the results have been pretty impressive. We had one patient who was pre-cancerous and we were able to get him treatment. We have helped other patients control diabetes." She notes that the community mental health center is the main point of healthcare access for many SDMI clients, so if they don't address their primary care needs in that setting, these clients may not receive any preventative care for chronic and acute conditions. "We can be more preventative in our care when we have an integrated model and get people stabilized more quickly. This hopefully decreases healthcare costs such as ER admissions, which is really important." Tressie White of the Leo Pocha clinic put it this way: "I always look at the patients. They are receiving all of the benefits. If you provide integrated care, the client is going to get better results and success."

Challenges to Integration

Despite the many benefits to integration, there are also a number of barriers that Montana providers face as they seek to create more integrated models.

Lack of an existing behavioral health system in Montana:
As documented above, Montana's substance abuse treatment and mental health treatment systems operate separately with distinct systems for youth and adults, administration, licensing, and payment (particularly payment for Medicaid). Before Montana can fully implement IBH, the state will need to identify and institute structural changes that encourage and support a behavioral health system that is functional, holistic, and patient-centered.

Regulatory silos:
The regulatory and administrative silos in the public mental health and substance abuse disorder treatment systems were a frequent topic of comments in the interviews conducted. Jodi Daly explained, "One of the biggest barriers is administrative rules about how we do treatment. Right now, if someone comes to us there are required intakes with certain criteria for each silo (substance abuse disorders, mental health, and primary care), which is duplicative. We need one treatment plan and the ability to share information. So we are not just assessing, assessing, assessing." Dan Ladd stated that, "To do good work, you have to fight against the system the whole way. In the public mental health system in Montana, we spend tens of millions of dollars every year, and we need to restructure how these dollars are used. The fee for service system is at odds with coordination and doesn't pay for quality care. We need to change the way that Medicaid dollars are spent, and we need to have the support of DPHHS for the Medicaid billing change. We keep getting waivers and doing pilot projects but the change in reimbursement needs to be integrated into the Medicaid block grant." Joan King said that nationally, each state that moves toward integration has had to address the regulatory environment barriers and interpretation of laws that regulate what kind of providers can be at what sites. She explains, "Without payment reform and changes in what services can be billed to Medicaid and other third party payers by various providers, Montana cannot create sustainable and long-lasting changes in systems."

Reliance on a fee-for-service system:
The Montana Medicaid program and many private payers in the state rely on a fee-for-service payment system. Fee-for-service reimbursement incentivizes the provision of covered services, not quality services, and does not provide incentives for the team-based approach that is central to the IBH model. In the surveys conducted for this report, FQHCs, which currently receive cost-based payments for care, were much more likely to report the use of IBH models (94.0% of responding FQHCs reported fully integrated services compared to 0.0% of substance abuse treatment providers and 6.0% of community mental health centers). Expanding the opportunities for more types of providers to receive bundled and cost-based payments versus relying on fee-for-service payment structures may bolster Montana providers' ability to offer team-based, integrated care.

Suboptimal utilization of and support for the behavioral healthcare workforce:
As documented above, Montana's behavioral healthcare workforce is concentrated in the more populated areas of the state, with few licensed providers in rural and frontier communities. Thus, workforce shortages may be an important barrier to implementing IBH, particularly for clinics located in rural areas. In addition, several interviewees noted that not every provider is suited for an integrated care team. It is essential to find a flexible provider who is willing to learn new ways of operating; for instance, a behavioral health provider who is comfortable with much shorter interactions in a primary care setting versus the hour-long appointments more common in a mental healthcare setting.

The need for integration within the community, not just in a single clinic:
Beyond intra-agency integration, it is also critical to address community-wide collaboration and coordination with behavioral health services. Integration at the community level can improve care through sharing healthcare information and referrals more seamlessly, and through inter-agency collaboration to provide the optimal level of care for each patient. A repeated theme in many of the key informant interviews was the long wait time for patients to be seen at community mental health centers, particularly psychiatrist appointments. Based on stakeholder interviews, it appears that many communities in Montana operate on a "first come, first serve" basis, rather than developing a coordinated system in which patients are triaged to an appropriate level of care. Thus, patients with milder diagnoses that could be treated by a primary care provider may end up being seen by a psychiatrist, while patients with SDMI may face long wait times to see a behavioral health specialist. This creates a bottleneck in some facilities, particularly at community mental health centers, which are not just seeing the SDMI patients, but may also be seeing lower-acuity patients who could be adequately treated by a primary care provider. Based on the reports of providers, there appears to be a need to better optimize the use of community mental health centers and other high-level behavioral health providers to serve patients with SDMI who are decompensating or needing intensive levels of treatment and therapy, while equipping primary care providers to effectively care for clients with less severe behavioral health concerns and SDMI patients once they are stabilized.

Competition between healthcare providers:
In a state that already has a shortage of behavioral health providers, and that has long entrenched silos for service provision, competition for resources and staff may be another barrier to inter-agency collaboration on IBH. One mental health center administrator related a challenge that occurred when she had piloted an IBH project with an FQHC, saying, "We went out thinking we really want to partner to do behavioral integration, so we embedded one of our therapists in a clinic. She was doing such good work that the FQHC just hired her away into their clinic at a higher wage. Even with good intentions, there are not good incentives to do integration and to partner across sectors; hiring away can be a disincentive. FQHCs don't have to play with us and they have better funding opportunities." This scenario, trying to develop partnerships and supporting integration only to have good staff hired away by the partner facility, was mentioned several times in interviews. Those supporting integrated models in Montana need to be aware of this dynamic and the potential for conflict and competition that may arise.

Information sharing:
Another barrier mentioned by a number of stakeholders is information sharing. Most providers are adopting EHRs, but the systems don't communicate with each other and there is presently no Health Information Exchange (HIE) in Montana. Also, complex HIPAA regulations make providers reticent to share information outside of their practice, so moving to an integrated model with shared treatment planning and team-based care is foreign to many providers. As one provider put it, "None of us have a way to get our systems to talk to one another."

The stigma against the mentally ill population:
Many healthcare providers interviewed are fearful about opening their practice to mentally ill patients because of the stigma associated with treating behavioral health clients. John Wilkinson, the former head of the National Association of Social Workers MT and a NAMI advocate puts it this way: "The number-one issue with mental illness is stigma. Not only in the general public, but amongst healthcare providers." Matt Kuntz of NAMI Montana noted that, "People like the theory of integrated care, but the reality scares providers." Jodi Daly discussed primary care providers' initial reticence to serve severely mentally ill clients as part of an integrated team. **"**There are a ton of different narratives about the people we serve. Our doctors have to practice differently when they are working with an SDMI population. For instance, they can't rely as heavily on their nurses and it takes more time. Several of the doctors who work with us were nervous to start serving this population, but now they love it. But it's a paradigm shift."

Defining the scope of practice:
Community mental health centers and primary care centers may naturally differ in the spectrum of mental illness that they are comfortable treating. Whereas treating a patient in mental health crisis or someone with chronic SDMI is part of the routine scope of practice for a mental health center, a number of primary care providers interviewed for this project expressed concerns about caring for complex SDMI patients. John Felton describes defining and sticking to a clear scope of practice as the biggest challenge to implementing an integrated model in Montana. He explains, "Our medical staff has built a pretty clear scope of work for our Mental Health and Behavioral Health services. But we still get many acutely ill patients sent to us, patients discharged from state hospital with written orders to 'Go to Riverstone Health.' But we are trying to address what can be done for mental health in the primary care setting, so we have limited our scope. When we first limited our scope there was pushback from the community, but within a few months most of the hospital-based primary care practices adopted the same scope. No one would send a patient to our FQHC for a heart transplant, but because of the lack of services for mentally ill clients, acutely mentally ill people are referred to our primary care practice for mental health services."

This sentiment was echoed by a number of other providers piloting integrated models who noted that providers are uneasy about jeopardizing their practice and being forced to treat patients who are outside of their realm of expertise.

National experts interviewed for this project noted that with robust training, support, referral pathways and psychiatric consultation, primary care practices can effectively treat patients with SDMI. In fact, this is one of the defining features of the best IBH models nationally—an ability and willingness to treat complex mental health patients to relieve pressure from higher levels of mental health care at community mental health centers and in inpatient settings, which are often over capacity. As Montana moves toward a more integrated model, defining the scope of practice for these initiatives will likely be a critical and evolving point of discussion.

Measuring and defining success:
Some of the challenges related to supporting IBH have more to do with measurement and making the case for its financial and health benefits for patients. Several providers said that Montana's current systems of measurement for substance abuse and mental health programs are not adequate. Jodi Daly explained that, "In Montana, there is not agreement on what outcomes we should be tracking for behavioral health. For example, we track 'Recovery Markers,' which I can guarantee you are just one more thing we have to do to get payments. In 10 years of tracking data for the state, I have only gotten back two reports on the Recovery Markers we have tracked. And the reports weren't clinically useful. It's just a demographic report. We need to move beyond that and through the layers to really know if we are providing quality care." Other providers who are working on developing more integrated models described the challenges they are facing measuring the effect of their integrated system. Dr. David Mark put it this way: "It's hard to demonstrate the financial sustainability and viability of an integrated model—it is much more challenging than we thought. We need to be able to define success from a financial sustainability perspective."

Opportunities to Advance IBH in Montana

There are many committed and caring healthcare providers serving behavioral health clients throughout Montana, some of whom are already developing Integrated Behavioral Health models within their own organizations. Moreover, a number of state-level initiatives are beginning to establish supportive administrative functions. Despite these efforts, most patients in Montana do not have access to robust IBH systems. This section identifies actions that can be taken to advance IBH in Montana.

Develop a coordinated, statewide integration initiative:
With multiple early pilot projects underway, a coordinated, multi-stakeholder Montana initiative effort to coordinate IBH activities may help to support consistent, high-quality implementation, enable evaluation, and effectively organize discussions to guide any needed structural changes. Those involved in other state and national initiatives who were interviewed for this report noted that a neutral third party may be the most effective convener, given the sensitive questions of policy, financing, and competition inherent to healthcare systems change work.

Jumpstart change by funding pilot projects that support integration at the local level while fostering long-term sustainability:
Other initiatives, such as the Maine Health Access Foundation's Integrated Care Initiative, report that targeted grantmaking can help jumpstart the integration process, by incentivizing providers to begin to hire integrated staff and develop better systems. The national models that are most successful addressed sustainability both by working with grantees to change their clinics' policies and practices and to embed integration into clinic systems, and by providing grants to advocates and other state-level partners focused on driving policy change and payment reform work at the state level. Another nationally successful grantmaking strategy has been that of developing "learning communities" where grantees that are moving toward integration share resources and insights into making this model work in the local setting. These learning communities' successes and challenges can then inform future stages of grantmaking for integration while providing insight for additional providers who join the movement.

Integrate administrative systems at the state level:
DPHHS and/or a coordinated group of stakeholders should review the current administration, regulatory policy, and licensing structure of the divisions that support the mental illness and substance abuse disorder treatment systems, and identify specific rule changes, state plan amendments, or code revisions that could be made to enable a more integrated system. The current Medicaid expansion offers an important policy window where such policy and administrative changes could occur.

Reform the payment system for mental illness and SUD treatment:
DPHHS and/or a coordinated group of stakeholders should review the current payment structure for substance abuse disorder and mental illness treatment to identify specific rule changes, state plan amendments, or code revisions that could be made to enable a more integrated system, incentivizes a coordinated and team-based approach to IBH, and supports recruitment and retention of behavioral health providers by ensuring adequate reimbursement. The payment reform discussions created by the SIM grant, the PCMH initiative, and other state-level initiatives provide a natural opportunity to examine ways to support improved integration of mental health care and SUDs treatment, as well as how to support more widespread implementation of IBH. Exploring value-based and bundled payments through initiatives like PCMH and the SIM grant offer important opportunities to advance this recommendation.

The CMS Medicaid Health Home program offers another important opportunity to create a payment structure that promotes effective service delivery. Under the Medicaid Health Home program, states have latitude to develop pilot programs that offer enhanced reimbursement for providing more integrated and effective services. A Medicaid IBH Home could, for example, advance the integration of primary care into the community-based mental health facilities, which care for the highest-cost, high-risk behavioral health clients in the state. Community mental health centers are often the sole or primary healthcare access point for these individuals, so integrating primary care into their services is critical.

Support local innovation to address community-specific needs.
Any statewide initiative should encourage local level policy work and reforms. In interviews for this project, several advocates noted that political support for behavioral health reform is often lacking at the state level, but that much innovation can occur at the county level or in local jurisdictions. For example, there may be opportunities

to consider how county-level collaboration between corrections and behavioral health could more efficiently and effectively address crimes committed by individuals with mental illness or substance abuse disorders. A statewide initiative that is working to fund local innovation may facilitate sharing of policy reform successes between jurisdictions to help drive change.

Address the workforce issues and support alternative ways to access providers:
The shortage of behavioral health care providers, dually-licensed providers, and prescribers—particularly in rural and frontier communities—must be addressed if a more integrated behavioral health model is to be successful in this state. There are several promising opportunities to address the behavioral health workforce concerns in Montana:

1. Support the development of a psychiatric residency, an idea currently being explored by Billings Clinic and partner organizations.
2. Support Montana University and College degree programs for behavioral health professionals, like the Psychiatric Nurse Practitioner program at MSU-Bozeman, and MSW and LAC programs at universities and tribal colleges in the state.
3. Ensure efficient use of existing resources by supporting communities to develop plans for care coordination at the community level that create systems for triaging and referring patients to the appropriate level of care. Incentivize collaboration, not competition, between providers, including sharing treatment plans, optimizing referral pathways, and co-locating providers.
4. Optimize the use of tele-health services in rural and frontier communities to enhance access to skilled behavioral health providers.
5. Develop better systems and more opportunities for psychiatry consultation in primary care practices. Advancing relationships between primary care and psychiatry will be critical to ensuring access to psychiatry resources in underserved areas.

Support robust training for providers:
National experts interviewed for this reports noted that robust and ongoing training is key to the success of IBH projects. As noted above, developing an IBH model is a paradigm shift in most practices, and it requires the right types of providers, with the right mindset, with robust and ongoing training to successfully implement. Any statewide effort in Montana could provide robust support for evidence-based training for participating healthcare staff in order to successfully implement this paradigm change. Montana should build on the work already being supported by Montana Healthcare Foundation, such as the Integrated Behavioral Health curriculum that will be implemented at the University of Montana, and the multiple communities planning and piloting IBH models throughout the state.

Make the business case for integration:
To engage hospitals, clinics, and payers in an integrated project long-term, Montana must make the business case for this model of care—namely, that it can improve health outcomes and save money over time. National models indicate that IBH models can reduce care or at least improve outcomes without increasing overall costs.[61] John Griffin, Medical Director of Blue Cross Blue Shield of Montana, stated, "You have to make the business case for maintaining the behavioral health consultant. Hospital systems and private clinics can't sustain these new staff and models if it's just good for the community but they can't pay for it. So then we'll need to figure out a way to engage the payers in the collaborative conversation about how to make it work from the standpoint of a payment methodology. We'll need to make the business case for the payers as well, and show them, if you invest in this type of a program, this is the return that you can generate both in health and cost savings." Griffin noted that hospital systems are already concerned about hospital readmissions and are being penalized for high readmission rates by Medicare, so linking the IBH model with increasing clinics' ability to manage complex patients in lower-level care may be an effective way to garner support for this model. IBH has been shown to

improve outcomes in important drivers of health costs, such as smoking, diabetes, and depression; another area of focus might be super-utilizers, those individuals who drive many of the healthcare cost, and who have been shown to have high rates of behavioral health concerns[62]. Private payers interviewed for this model noted that they are already entering into Patient-Centered Medical Home Contracts with providers across the state, providing enhanced, bundled, stratified and per-member-per-month payments, depending on the contract. Payers are already providing bonuses for clinics meeting quality metric and enhanced payments for clinics serving clients with complex health needs. IBH advocates will need to place particular emphasis on evaluating pilot efforts in order to provide evidence on which payers can base new payment models.

Model Montana's initiative on other successful models, particularly those in rural areas:
Though much of the integration work in the U.S. has occurred in urban areas, Montana can take lessons learned from other providers, particularly those in rural areas, who have successfully designed integrated systems. Some helpful examples to reference include Cherokee Health Systems in East Tennessee, Missouri's Behavioral Health Home Initiative, and the Shenandoah Valley Medical System in Virginia.[63] Montana should also be aware of the emerging trends in this field, including a focus on holistic models of wellness and trauma-informed care that are being shown to be effective in integrated settings nationwide.[64]

Agree on the definitions, scope, and measurement of integrated care, while allowing for flexibility:
One important role that a state-level initiative can play is to help build consensus around the definitions of integrated care, the scope of behavioral health services that will be expected in integrated models, and how to measure and evaluate integration. To make the case for policy change and payment reform, it is vital that clinics be supported to define their work and scope and then measure and evaluate outcomes with clear metrics. Because Montana is a rural state, the small clinics funded to develop an integrated model will likely not have the expertise to develop measurable outcomes and metrics and track them over time. Instead, a statewide initiative can bring resources to bear for evaluation, ensuring a well-funded, robust tracking plan while providing consultation and technical assistance to local sites. If Montana succeeds in clearly defining integration and implementing metrics for these sites, then advocates can collect consistent state-level data to make the case for how integration improves care. Patient satisfaction surveys, provider site self-assessments, and patient outcome and process data are all important to paint a picture of the value of integration. Though it will be helpful to clearly define integration and require specific and standardized metrics at all sites receiving funding, it may be wise to keep grantmaking opportunities open to a wide variety of providers—FQHCs, private clinics, community mental health centers, tribal programs, urban Indian clinics, and/or substance abuse disorder treatment programs— in the initial stages of grantmaking to allow all interested parties in this rural state to develop useful models and see which sites are most adept and successful at implementing this model.

Conclusion

There are many opportunities to improve the behavioral health care system in Montana and to ensure that more individuals get access to much needed care. Montana's high suicide rates reflect, in part, an epidemic of untreated mental illness and substance abuse disorders. Practical, systemic reforms in the state's behavioral health treatment system are essential, and offer tremendous potential as a way to improve both behavioral and physical health outcomes, as well as to improve the value of our investments in healthcare. Other state and local models reviewed in this report show that a unified, statewide initiative that transforms care at the local level and supports policy change and payment reform statewide is feasible and has tremendous potential for effectiveness. With the right partners and support of the many providers who are already working towards integrated care, Montana can greatly improve access to these much needed services. As one advocate said, "We need to develop a system where there is "no wrong door"—where clients in need of physical or mental health services find the support they need no matter where they go for care. We need to ask the question, 'What kind of systems can we build to meet the needs of the people who really need help in our communities?' "

Appendix A: Community Mental Health Centers in Montana

Name	Location (s)	Serving
ALTA Care	Statewide CSCT provider	Children
AWARE Youth Day Treatment Program	Anaconda, Billings, Bozeman, Butte, Dillon, Glendive, Great Falls, Kalispell, Miles City, Missoula	Children and Adults
Billings Community Crisis Center	Billings	Adults
Bitteroot Valley Education Cooperative	CSCT provider in Western Montana	Children
Center for Mental Health	Helena, Great Falls, Havre, Cut Bank, Shelby, Chinook, Conrad, Boulder, Choteau, Whitehall	Children and Adults
Community Crisis Center	Billings	Adults
Eastern Montana Community Mental Health Center-Miles City	Scobey, Glasgow, Miles City, Colstrip, Forsyth, Glendive, Sidney, Plentywood, Malta, Wolf Point	Adults
Full Circle Counseling Solutions	Stevensville, Billings, Great Falls	Children
HKJ Inc DBA Winds of Change	Missoula	Children and Adults
Intermountain	Helena, Kalispell	Children
Kalispell Regional Behavioral Health	CSCT provider in Kalispell, Whitefish, Big Fork and Lakeside	Children
L'esprit Incorporated	Livingston	Children
Montana Community Services	Billings	Adults
Montana State Hospital Transitional Services	Deer Lodge and Warm Springs	Adults
Mountain Home Montana	Missoula	Children
New Day, Inc	Billings	Children
Northern Winds Recovery Center	Browning	Children and Adults
Partnership for Children Mental Health Center	Missoula	Children
Rimrock Foundation	Billings	Children and Adults
Southcentral Regional Mental Health Center	Billings, Lewiston, Hardin, Big Timber, Columbus, Red Lodge, Roundup	Children and Adults
Sunburst Mental Health Services	Kalispell, Libby, St. Ignatius, Polson	Children and Adults
Three Rivers Mental Health Solutions	Missoula, Stevensville	Adults
Western Montana Regional Mental Health Center	Bozeman, Hamilton, Libby, Butte, Thompson, Ronan, Livingston, Missoula, Kalispell, Dillon, Anaconda	Children and Adults
Yellowstone Boys and Girls Ranch	Billings, Lewiston, Dillon	Children
Youth Dynamics, Inc	Boulder, Billings, Wolf Point, Miles City, Great Falls, Butte, Bozeman, Colstrip, Dillon, Glasgow, Havre, Helena, Kalispell, Livingston, Malta, Shelby	Children

Appendix B: State Approved Substance Abuse Treatment Facilities in Montana

City	State Approved Substance Abuse Treatment FacilitY(S)
Bozeman	Gallatin County
Great Falls	Benefis Healthcare, Gateway Community Services and Indian Family Health Clinic
Helena	Boyd Andrew Community Services
Havre	Bullhook Community Health Center
Conrad	Center for Mental Health
Superior	Choices for Change Counseling
Browning	Crystal Creek Lodge
Glendive	District II Alcohol & Drug Program
Miles City	Eastern Montana Community Mental Health Center-Dependency Services
Eureka	Flathead Valley Chemical Dependency Clinic Satellite Clinic
Kalispell	Flathead Valley Chemical Dependency Clinic
Harlem	Fort Belknap Chemical Dependency Program
Helena	Helena Indian Alliance
Billings	Indian Health Board of Billings, Journey Recovery, New Day, Rimrock Foundation, Youth Dynamics
Missoula	Missoula Urban Indian Center, Recovery Center of Missoula, Western MT Addiction Services-Turning Point
Butte	Montana Chemical Dependency Center, Southwest Community Health Center, Recovery and Treatment (SMART)
Big Sandy	New Horizons Recovery Satellite Office
Fort Benton	New Horizons Recover
Livingston	Southwest CD Program
Polson	Western MT Addiction Services Satellite Office
Box Elder	White Sky Hope Center
Marion	Wilderness Treatment Center

Appendix C: Footnotes

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[21] (1) "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (1)(a) or (b) and (c). The person must also meet the requirements of (1)(d). The person:

(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital within the past 12 months; or

(b) has recurrent suicidal ideation within the past 12 months, a history of suicide attempts, or a specific plan for completing suicide; and

(c) has a primary diagnosis of one of the following (excluding "mild, not otherwise specified (NOS)," unspecified, or due to "physiological disturbances and physical factors"):

(i) schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder;

(ii) bipolar I disorder and bipolar II disorder;

(iii) major depressive disorder;

(iv) panic disorder with agoraphobia or panic disorder without agoraphobia;

(v) obsessive-compulsive disorder;

(vi) posttraumatic stress disorders;

(vi) remains as proposed, but is renumberd (vii).

(viii) autism spectrum disorders; and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least six months or a predictable period over six months, as indicated by the presence of at least three of the following indicators:

(i) and (ii) remain as proposed.

(iv) through (vi) remain as proposed, but are renumbered (iii) through (v).

(vi) the person maintains housing only with ongoing supervision, is homeless, or is at imminent risk of homeless ness due to mental illness

[22] Addictive and Mental Health Disorder Division. Presentation to the 2015 Health and Human Services Joint Appropriation Subcommittee. Legislative Fiscal Division Budget Analysis. Volume 4. Page B-126-B151.

[23] The Definition of Serious Emotional Disturbance in Montana according to the CMHB Medicaid Services Provider Manual (October 2015) is:

(1) As a result of the diagnosis of the youth as determined above and for a period of at least six months, or for a predictable period over six months. The youth must also consistently and persistently demonstrate behavioral abnormalities in two or more spheres, to a significant degree, well outside normative developmental expectations. The behavioral abnormalities must have either been in existence for six months or must be reasonably predicted to last six months. They cannot be attributed to intellectual, sensory, or health factors. To qualify a youth must have displayed two or more of the following: (a) failure to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures; (b) failure to demonstrate or maintain developmentally and culturally appropriate peer relationships; (c) failure to demonstrate a developmentally appropriate range and expression of emotion or mood; (d) disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings; (e) behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or (f) behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment. (2) Serious emotional disturbance (SED)

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[29] Addictive and Mental Health Disorder Division. Presentation to the 2015 Health and Human Services Joint Appropriation Subcommittee. Legislative Fiscal Division Budget Analysis. Volume 4. Page B-126-B151.

[30] http://leg.mt.gov/bills/mca/53/24/53-24-208.htm

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[35] Addictive and Mental Health Disorder Division. Presentation to the 2015 Health and Human Services Joint Appropriation Subcommittee. Legislative Fiscal Division Budget Analysis. Volume 4. Page B-126-B151.

[36] Addictive and Mental Health Disorder Division. Presentation to the 2015 Health and Human Services Joint Appropriation Subcommittee. Legislative Fiscal Division Budget Analysis. Volume 4. Page B-126-B151.

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[38] Correspondence with DPHHS Children's Mental Health Bureau, December 2015

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