Primary Care and Behavioral Health Integration

John O’ Brien
Senior Advisor on Healthcare Financing
Major Areas of Effort

- Primary Care and Behavioral Health Grantees
- SAMHSA/HRSA Center for Integrated Health Solutions
- Section 2703 Health Home Consultation
SAMHSA Approach to Primary Care and Behavioral Health Integration

• Integration needs to be bi-directional:
  – MH/SUD in primary care
  – Primary care in MH/SUD settings

• Providers need supports to be effective

• Cant do this alone—CMS/HRSA are important partners

• States and providers are critical partners in making a difference
Primary Care and Behavioral Health Integration

• Program purpose:
  – To improve the physical health status of people with SMI and those with co-occurring substance use disorders by supporting communities to coordinate and integrate primary care services into publicly funded community-based behavioral health settings

• Expected outcome:
  – Grantees will enter into partnerships to develop or expand their offering of primary healthcare services, resulting in improved health status
SAMHSA’s Primary Care And Behavioral Health Integration Program

• Population of focus:
  – Those with SMI and co-occurring substance use disorders served in the public behavioral health system

• Eligible applicants:
  – Community behavioral health agencies, in partnership with primary care providers
  – Currently 53 participating providers
Services Delivery

• Facilitate screening and referral for primary care prevention and treatment needs

• Provide and/or ensure that primary care services and referral be provided in a community-based behavioral health agency

• Develop a registry/tracking system for all primary care needs and outcomes

• Build processes for referral and follow-up for needed treatments with primary care providers

• Offer prevention and wellness support services (>10% of grant funding)
SAMHSA/HRSA Center for Integrated Health Solutions (CIHS)

• Technical Assistance Jointly Funded by HRSA and SAMHSA:
  – 4.5 million/year work (co-funded with HRSA) a training and technical assistance center—Center for Integrated Health Solutions
    • Assist with practice development
    • Provide assistance to SAMHSA re: consultation to States

http://www.centerforintegratedhealthsolutions.org
Health Home Quote

“Health Homes are a slippery slope”

Health Home…..

Nursing Home…..

Funeral Home”

cantankerous physician
SAMHSA’s Role

• Section 2703 require States to consult with SAMHSA regarding their health home SPA:
  – Individuals with a serious and persistent MH condition
  – Individuals with other chronic conditions that may be at risk of a BH condition:
    • Depression
    • Alcohol Use/Misuse
    • Prescription and Other Drug Misuse
SAMHSA Role

• Areas of Focus for Consultation:
  – Screening instruments for at-risk individuals
  – Models for integrating care—bi-directional approach
  – Review of team—suggestions regarding different approaches
  – Client flow
  – Interim outcomes
SAMHSA Role

• Staff:
  – Physician consultants
  – Financial consultants
  – Quality consultants
  – HIT Consultants

• Contractors
  – Screening and Brief Intervention
  – National provider organizations for (MH/SA)
What Is SAMHSA Seeing?

- Struggling with current case management approaches and how they fit/don’t fit in to HH approach.
- Substance abuse is not as prominent in planning.
- Screening (depression, alcohol and substance use) is not initially discussed.
- Seeing more discussion regarding designated provider (not much team).
What is SAMHSA Seeing?

• Not always clear about what you are trying to address—
  – Non-specific problem identification
  – Problem is not sized
  – Therefore the fix-its don’t hang together

• The clients experience of care is missing:
  – Outreach/Engagement
  – Front door experience
  – Role on Team
What Else Is SAMHSA Seeing?

• Not real integration—primary care participation is not very strong
  
  BUT

• Partnership between Medicaid and MH/SA authorities

• Attention to thoughtful approaches to EHR and interoperability
More Information?

http://www.samhsa.gov/healthReform/healthHomes
“Health Homes” and Behavioral Health/General Medical Care Integration

On the Banks or in the Mainstream?

Harold Alan Pincus, MD
Professor and Vice Chair, Department of Psychiatry
Co-Director, Irving Institute for Clinical and Translational Research
Columbia University
Director of Quality and Outcomes Research
New York-Presbyterian Hospital
Senior Scientist, RAND Corporation

National Association of Medical Directors (NAMD Meeting)
11.09.2011
The Bottom Line

- Co-morbidity of behavioral disorders and general medical conditions is highly prevalent (especially in Medicaid populations).

- This pattern of co-morbidity is especially concentrated among those who have high costs and frequent hospital admissions.

- These individuals die at younger ages.

- Impacts and solutions go both ways across the GM/BH divide:
  - Primary Care patients needing Mental Health Care
  - Mental Health patients needing Primary /Specialty Medical Care

- Evidence-based models for integrating care have been well documented.

- These models have not been widely implemented due to structural barriers and financial disincentives.

- Health Home option provides flexibility and incentives and opportunity.
BH/GMC Clinical Examples

• 35 year old male with schizophrenia, diabetes, and tobacco dependence
  – Can expect up to 25 year shortened life span, increased medical costs

• 25 year old HIV+ female IV drug user with PTSD
  – Frequent ED visits, non adherence to meds, increased medical costs

• 60 year old female with diabetes, CHF and depression
  – Frequent (re-) hospitalizations, poor self management and adherence, early candidate for LTC
Currently, Poor Quality and Care Coordination for All Populations

- Patients primarily in contact with the general medical sector with co-morbid BH conditions (e.g., depression)
  - Not treated or treated as acute problems with little follow-up

- Patients with severe and persistent BH conditions (e.g., schizophrenia) and treated in BH specialty settings
  - Poor self-care, medications worsen general medical conditions
  - Limited provider capacity and incentives for
    - Accessing treatment of co-morbid medical conditions
    - Preventive and wellness care

- Medical and BH providers operate in silos
“Crossing the Quality Chasm”

National Association of Medical Directors (NAMD Meeting)
11.09.2011
Crossing the Quality Chasm

"Quality problems occur typically not because of failure of goodwill, knowledge, effort or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized."

The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work: Changing systems of care will!
Improving the Quality of Health Care for Mental and Substance-Use Conditions

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

QUALITY CHASM SERIES
Overarching Recommendation 1

The aims, rules, and strategies for redesign set forth in *Crossing the Quality Chasm* should be applied throughout M/SU health care on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general health care.

National Association of Medical Directors (NAMD Meeting)
11.09.2011
Overarching Recommendation 2

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind / brain and the rest of the body.
Don’t Split Mind and Body

National Association of Medical Directors (NAMD Meeting)
11.09.2011
General Medical/Behavioral Health Integration Questions

• Why not?
• Who?
• When?
• Where?
• How?
• For whom?
• Why?
Why Not?

- Historical issues
- Conceptual/Definitional Issues
- Stigma
- Multiple complex systems involved
- Communication problems
- Health IT imbalances
- Ambiguity of responsibilities
Who? Responsibility for Care

Primary Care Provider (PCP)

Behavioral Health Specialist (BHS)
<table>
<thead>
<tr>
<th>Risk Factor Identification/Prevention</th>
<th>Diagnosis/Assessment</th>
<th>Short-term Management</th>
<th>Continuing Care</th>
</tr>
</thead>
</table>

When?
How?

- Integrated Team
- Collaborative Care
- Consultative Care
- Referral
- Independent
- Autonomous (PCP)
- Autonomous (MHS)
Evidence-Based Chronic (Planned) Care Approach

Community

Resources and Policies

Health System

Health Care Organization

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Productive Interactions

Patient-Centered

Coordinated

Timely and Efficient

Evidence-Based and Safe

Informed, Empowered
Patient and Family

Prepared, Proactive
Practice Team

Improved Outcomes

National Association of Medical Directors (NAMD Meeting)
11.09.2011
Where?
Models of Linkage / Integration

Embedded PCP in BHS

Co-location of BHS in PCP

Unified

Coordination / Collaboration

National Association of Medical Directors (NAMD Meeting)
11.09.2011
For Whom?

• Two Populations
  – General/Primary Care with mild to moderate BH conditions (e.g., anxiety, depression)
  – Severe/Persistent Behavioral Health Conditions (e.g., schizophrenia, drug dependence)

• Two Strategies
  – Mainstream
  – Separate BH Specialty Adaptations
Two Overall Strategies

Strategy 1: Primary Care Health Home

For patients primarily in contact with general medical sector (and mild to moderate BH conditions):

- Organize around primary care/general medical setting
- Apply evidence-based clinical and organizational strategies
- Design specific policy tools to hold medical providers accountable for meeting the BH care needs of patients.
Two Overall Strategies
Strategy 2: BH Health Home

For patients with severe and persistent BH conditions and primarily treated in a BH specialty setting:

• Organize health home around BH setting

• Apply evidence-based clinical and organizational strategies

• Develop specific policy tools to assure access to high-quality primary care and non-BH specialty care
Evidence-Based Integration Mechanisms

- Clinical integration of services, or
- Co-location of services
- Formal agreements with external providers
- Shared patient records
- Screening and longitudinal monitoring
- Clinical registry
- Care management
- Evidence-based guideline support/training
- “Measurement-based”/ “Stepped” care
- Close collaboration with other specialty, substance use and human services providers

National Association of Medical Directors (NAMD Meeting)
11.09.2011
Policy Strategies

• Medical/ Health Home Models
  – Measurement-based care
  – “Relentless” follow-up

• Accreditation
  – New NCQA criteria expand BH expectations for PCMH
  – Need equivalent criteria for Health Homes?

• Quality Measurement/Incentives
  – BH populations as “disparities” category?

• Shared Accountability Across BH and GM Providers
  – For Quality and Costs

• Payment Related to Complexity
  – Tiers/Risk Adjustment

• Support Improved Communication
  – EMRs, Health Information Exchanges (with protections)

• Training and Technical Assistance

• Flexibility
BH/GMC Programmatic Examples

- SAMHSA Primary and Behavioral Health Care Integration Program
- Minnesota DIAMOND Project
- Community Care of North Carolina
- IMPACT Model
- PCARE Model
- SAMHSA/HRSA-funded Technical Assistance Center (NCCBH)
Top 10 Issues
General Health/Mental Health Relationships

1. Partnerships
2. Formalize
3. Accountability (Shared)
4. Referral
5. Consultation/Evaluation
6. Information Flow
7. Money
8. Quid Pro Quo
9. Maintenance/Sustainability
10. Generalize

National Association of Medical Directors (NAMD Meeting)
11.09.2011
A Few Lessons Learned

• Systematic data (removes myths)
  – Balance structure/process/outcomes PI

• K.I.S.S.

• Relationships are key
  – Formal and informal connections/partnerships

• Communication is essential
  – In all directions (360 degrees)

• Culture/Leadership make huge difference
Top 10 Issues: A Few Lessons Learned
(cont’d.)

• Tools usher in “MBC” behavior
  – (eg PHQ-9)

• Relentless follow-up gets results
  – (longitudinality)

• Training for competence with ongoing reinforcement

• Quality improvement is your friend

• Flexibility in roles, time, structure, workflow
Why

It’s the patient, stupid
Back-up Slides
• Evidence-Based Practices
  – specific interventions
  – medications, psychotherapies, team-based, etc.
  – appropriateness/fidelity measurement
  – training, supervision

• Measurement-Based Care (MBC)
  – clinical measures (e.g. HA1c, PHQ-9)
  – systematic, consistent, longitudinal
  – action-oriented

• Best Practices/Context
  – accessibility
  – therapeutic alliance
  – patient centeredness
  – cultural competence

National Association of Medical Directors (NAMD Meeting)
11.09.2011
Opportunities and Barriers in Behavioral Health Integration: Perspectives of the State Behavioral Health Authorities

National Association of Medicaid Directors
November 9, 2011

Joel E. Miller, Senior Director of Policy
National Association of State Mental Health Program Directors
Represents the $36.7 Billion Public Mental Health System serving nearly 6.9 million people annually in all 50 states, 4 territories, and the District of Columbia.

An affiliation with the approximately 220 State Psychiatric Hospitals: Serve 200,000 people per year and 50,000 people served at any point in time.
Who are State Behavioral Health Authorities (SBHAs)?

- SBHAs recognized as state-wide government authorities responsible for coordinating and assuring the provision of high quality behavioral health (BH) services/supports for individuals with serious mental illness, severe child emotional disturbances and substance abuse disorders.
- Manage and coordinate behavioral health public policy, public safety and public welfare.
- Manage and coordinate behavioral health financing and coverage.
- Manage, improve and coordinate behavioral quality of care and delivery of services.
Funding Sources of State Behavioral Health Agencies: 2010

State General Funds: 38%
State Medicaid Match: 19%
Federal Medicaid: 29%
Medicare: 1.8%
MH Block Grant: 1.0%
Other Federal: 1.2%
Local: 2.4%
Other: 4%
State Other Funds: 4%

Total SMHA Revenues = $38.3 Billion -- 51 states reporting
State Budget Shortages and Impact on the Mental Health System
AGONY

Not All Pain Is Gain.
## Level of SMHA Budget Reductions:

**FY2009 to FY2011 Total $3.4 Billion in Cuts**

<table>
<thead>
<tr>
<th>Year</th>
<th>Average</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2009</strong></td>
<td>$36,849,116</td>
<td>$13,226,000</td>
<td>$0</td>
<td>$554,003,000</td>
<td>$1,216,020,843</td>
</tr>
<tr>
<td>(39 States)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FY 2010</strong></td>
<td>$29,123,575</td>
<td>$12,300,000</td>
<td>$0</td>
<td>$213,591,000</td>
<td>$1,019,325,136</td>
</tr>
<tr>
<td>(38 States)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FY 2011</strong></td>
<td>$37,981,650</td>
<td>$12,000,000</td>
<td>$0</td>
<td>$523,437,000</td>
<td>$1,177,431,138</td>
</tr>
<tr>
<td>(37 States)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: NRI/NASMHPD 2010 Survey on Impact of State Budget Shortages on State Mental Health Systems: Results based on 47 SMHAs Reporting*
Most of SMHA Budget Cuts are from General Revenue Funds

FY 2010

• 75% of Reductions from State General Funds
• 22% from Medicaid

(one state reported 100% of cuts from Medicaid)

– 100% of the Median State’s reduction was from State General Funds
# Closing State Psychiatric Hospitals & Hospital Beds (2010-2012)

<table>
<thead>
<tr>
<th>Types of Beds SMHAs are Closing</th>
<th>Acute Care</th>
<th>Long-Term Care</th>
<th>Forensic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>8 States</td>
<td>4 States</td>
<td>2 State</td>
</tr>
<tr>
<td>Adults</td>
<td>12 States</td>
<td>16 States</td>
<td>3 States</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Psychiatric Hospitals</th>
<th>SMHA Has Closed</th>
<th>SMHA is Considering Closing</th>
<th>Total Closed or Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 States</td>
<td>4 States</td>
<td>6 States</td>
</tr>
<tr>
<td></td>
<td>6 State Hospitals</td>
<td>6 State Hospitals</td>
<td>12 State Hospitals</td>
</tr>
<tr>
<td>State Hospital Beds</td>
<td>25 States</td>
<td>17 States</td>
<td>3,930 Beds*</td>
</tr>
<tr>
<td></td>
<td>2,198 Beds</td>
<td>1,732 Beds</td>
<td></td>
</tr>
</tbody>
</table>

*3,930 beds are over 8% of State Psychiatric Hospital Bed Capacity*

- 4 SMHAs were able to retain all the savings from closing state hospital beds to use within their MH System.

Preliminary Results based on 47 SMHAs Reporting
Increased Demand for Mental Health Services During the Recession

Percentage of States Experiencing Increased Demand for Services

- Community MH Services: 56%
- Crisis Services: 29%
- Emergency Room use of ED: 18%
- State Hospital - LTC: 18%
- Psychiatric Emergency Screening: 18%
- State Hospital - Acute Care: 18%
- Other Psychiatric Inpatient: 13%

Preliminary Results based on 47 SMHAs Reporting
People with Serious Mental Illness Experience 25 Years Lost Life: A Public Health Crisis

- **Smoking**
- Obesity
- Suicide
- Substance Abuse
- Inadequate Medical Care
PROBLEMS

No matter how great and destructive your problems may seem now, remember, you’ve probably only seen the tip of them.

www.despair.com
Key Factors Leading to Excess Mortality

• Health care system riddled with problems of fragmentation, duplication, quality issues.

• As long as delivery system consists of silos for BH, addiction and primary care = enormous barriers for individuals seeking integrated cost-effective and quality services.

• Silos will continue to exist until both real and perceived differences in the other’s “culture” are addressed & progress is made to reduce fears of encroachment on the other’s clientele or funding sources.

• The complexity of clinical factors is enormous for people with SMI in the public BH system. Among the risk factors contributing to these diseases are smoking, obesity, lack of exercise.
Evolving Models of BH and PC Service Integration

- **Practice Model 1:** Improving Collaboration between Separate Providers – minimal integration, separate systems
- **Practice Model 2:** Medical-Provided Behavioral Health Care – basic collaboration, periodic communication
- **Practice Model 3:** Co-location – basic collaboration on-site
- **Practice Model 4:** Disease Management – close collaboration in partially integrated systems
- **Practice Model 5:** Reverse Co-location – Similar to Model #4
- **Practice Model 6:** Unified Primary Care and Behavioral Health – close collaboration in fully integrated system
- **Practice Model 7:** Primary Care Behavioral Health – BH and PCP providers are part of the same team
- **Practice Model 8:** Collaborative System of Care – specialty providers are integrated with PC services
SBHA Roles

• Current situation is unacceptable! SBHAs believe they must be at the table and part of the solution in accelerating integration of BH services and primary care.

• BH system is under great duress as state budget cuts show over last few years.

• SBHAs have critical role to play in framing integration issue, providing guidance on implementation, supporting consumers & providers.
Models of Integrated Care in the States: Pennsylvania

- Demonstrations conducted by the Pennsylvania SBHA reveal valuable lessons on designing a system to improve outcomes and reduce costs by integrating physical and BH.
- Hybrid of Models 3 and 4 – Co-location and Disease Mgt.
- Guiding principles of the demonstration emphasized BH as part of overall health; integration of good health habits; prevention; and physical health interventions best achieved through local collaborations.
- Target population included people with SMI, co-occurring drug and alcohol use and co-morbid medical conditions.
- Two regional demonstration sites were selected with different health plans and BH carve-out plans.
• Collaborative care model is being used that is recovery-focused, team-based, and includes supports.

• Wellness Recovery Teams include a physical health professional (RN), a BH professional (Master’s in BH with co-occurring certification), and an administrative navigator.

• Data from three counties show a small increase (4%) in BH residential days and an increase in BH outpatient days (22%) but reductions in ER visits (-2%), inpatient hospitalization days (-42%) and physical health specialist visits (-18%).
Models of Integrated Care in the States: Pennsylvania, cont.

- Connected Care Pilot is based on the Patient-Centered Medical Home model with an integrated team and care plan to address physical, BH and social needs. Target population included members 18 years old or older, and have a SMI. High physical and high BH needs were defined by specific criteria.

- Of the 5,800 eligible Medicaid members, 850 consents were obtained from July 2009 to July 2010. BH providers were used to help obtain consents along with an incentive of a $25 gift card to complete the consent.

- Rigorous evaluation of the project is underway and incentive funds for the counties and health and behavioral health plans will be awarded on the basis of their performance on a series of measures.
Models of Integrated Care in the States: Missouri

- Initiated several programs to improve the health of people with SMI through DMHNet, a partnership comprised of Medicaid, Missouri Dept. of Mental Health, and Missouri Coalition of CMHC’s.

- Launched 3 programs focused on people with SMI many of whom are eligible for both Medicaid and Medicare: Improving Quality of Care for Persons with Schizophrenia; Chronic Care Improvement Program; Disease Management 3700 Project.

- *Improving Quality of Care for Persons with Schizophrenia*, DMHNet identified a sub-cohort of over 6,000 people with a diagnosis of schizophrenia (out of a total of 19,000).
Models of Integrated Care in the States: Missouri, cont.

• DMHNet undertook a program to improve quality of care by retraining CMHC case managers in chronic medical illnesses, training them to collaborate with PC providers. Takes in aspects of Models 3, 4 and 6.

• As challenges arose such as difficulties in communicating with providers or individuals not having a medical home, DMHNet made attempts to address issues and make improvements.

• One significant finding that in a sub-group that received substantial case management, net cost reduction when increases in opt. and case management were offset by decreases in ED and inpatient services.
Models of Integrated Care in the States: Missouri, cont.

- Second initiative involved providing enhanced management interventions through *Chronic Care Improvement Program (CCIP)* for people receiving care in CMHCs. CMHCs added PC nurse liaisons on-site at CMHCs.
- Elements of the program included performance outcomes with benchmark reports for ten HEDIS indicators and medication adherence for 7 different medication classes.
- Preliminary results found the program almost broke even after 18 months. Follow-up analysis showed a cost savings of 17% off expected trends.
- *The Disease Management 3,700 Project*, identified 3,700 Medicaid beneficiaries with SMI who are not dual eligible but among the 25% highest in utilization and costs.
Other SBHA Integration Projects

- **Illinois** -- played leadership role in statewide collaboration with the Community Behavioral Healthcare Association of Illinois.
- **Minnesota** – “10 by 10 Program” to improve life expectancy by 10 years in 10 years.
- **New York** -- Behavioral Work Group formed to address integration of substance use and MH services
- **North Carolina** -- statewide public/private partnership between PCP’s and Medicaid program with medical home as its center.
- **Rhode Island** – grants awarded under the SAMHSA/HRSA co-location program.
Key Lessons Learned

• Increase public-private partnerships by involving major players in the development of a shared vision -- include key governmental leadership, professional societies, major public and private payers, educational institutions, consumers, and provider representatives.

• Encourage payers to run integrated financial data for the purpose of analysis with regards to clinical and financial outcomes. This review may identify common areas of concern and potential opportunity that can be the basis for shared objectives.

• Develop a shared implementation plan that is driven by data, evidence-based guidelines, and consumer input.
Lessons Learned, cont.

• Walk through the model from multiple perspectives, taking into consideration state and federal policies, place of service, # of providers, authorization policies, and impact on medical visits and BH visits.

• Ensure that implementation tools are designed with input from PC providers, specialty providers, and consumers.

• T.A. and training during implementation will need to include clinical services, practice redesign, cultural competency, reimbursement, and policy. Reassure providers that integrated care is clinically beneficial and financially viable.
Lessons Learned, cont.

• Conduct T.A. -- training needs are going to be substantial for both PC and BH providers.

• Set realistic timelines for project and practice implementation.

• Share information with providers and other interested stakeholders when claims data and quality outcomes are measured.
“If you can’t imitate him, don’t copy him.”

Yogi Berra
Medicaid Options to Promote Integration – Key Issues

• In response to the ongoing severe budget shortfall situation, states have sought ways to reduce general revenue outlays while maximizing Medicaid revenues to pay for vital services.

• High prevalence of co-morbid conditions in Medicaid population makes existing silos of care for BH and PC unsustainable.

• In any given year, nearly half of all Medicaid beneficiaries will have a diagnosable MH or SU disorder. Nearly 70% of adults in Medicaid with a MH disorder have medical conditions and 29% of adults with medical conditions have MH disorders.
Medicaid Options to Promote Integration - Opportunities

• Opportunities abound for Medicaid programs to partner with SBHAs -- new delivery approaches available to states that hold the promise of reducing cost of treating co-occurring and medical conditions and improving outcomes for high-cost beneficiaries.

• 3 states have applied to CMS for approval of a Medicaid Health Home plan amendment (Missouri approved) and states are planning to apply. Option allows for the creation of health homes for persons with chronic conditions.

• Services offered under the home health option include comprehensive care management; care coordination and health promotion.

• For these services, a 90 percent federal match is available for 8 fiscal quarters after the amendment goes into effect. This is BIG!
Medicaid Options to Promote Integration - Challenges

Integration on 2 Levels: BH and PC and MH and SU

• Imperative that states address integrating BH and primary care. States undertaking a variety of projects to accelerate the integration of behavioral health and primary care.

• Imperative that states address co-occurring MH and substance use disorders due to prevalence (high as 70% co-occurrence in some states) and the health impacts, but obstacles remain -- perceived and real barriers to sharing information & different cultures of treatment.
COMMUNICATION

The only thing that keeps you from losing the slight amount of job satisfaction you do have is the fact that you don’t really know what is going on.
Thank you, and for more information on individual state integration efforts, please contact:

bob.glover@nasmhpdp.org or joel.miller@nasmhpdp.org or call at 703-739-9333