CHAD
Community HealthCare Association of the Dakotas

Behavioral Health White Paper

The purpose of this paper is to provide recommendations for advancing the behavioral health system of care among community health centers (CHCs) throughout North Dakota and South Dakota. The Community Healthcare Association of the Dakotas (CHAD) developed an active behavioral health work group to identify collaborative opportunities to improve the delivery of behavioral health services within the community health center network. Specifically, the group sought to identify gaps in care and barriers to delivering and expanding services to meet the needs of health center patients and communities. The data and recommendations in this paper are a result of that work.

Behavioral health services, including those focused on mental health and substance abuse treatment, have historically been delivered separately from primary care by specialty providers; however, there is now clear evidence about the importance of integrating behavioral health and primary care services to provide a patient-centered approach. While the role of specialty behavioral health services remains critical, there is also an important role for primary care in the management of commonly occurring behavioral health conditions such as depression, anxiety, and mild to moderate substance use concerns. One quarter of the patients seen every day by CHCs in the Dakotas have one or more behavioral health conditions. Primary care also plays an important role in screening for behavioral health concerns, including risk of suicide, and then either helping patients to manage those conditions or referring patients to partner organizations for ongoing coordinated care.

The recommendations shared at the conclusion of this white paper are designed to equip community health centers to serve as an effective part of the behavioral health care continuum. They are also designed to address long-standing challenges in the behavioral health system including a workforce shortage and inadequate reimbursement for behavioral health care. They also address the importance of telehealth, brief intervention, medication assisted treatment and suicide prevention.

Behavioral Health Needs and the Role of Community Health Centers

National impact of behavioral health conditions

Behavioral health conditions have a significant impact on the health of individuals, their families and communities. By 2020, mental health and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.[1]

The Substance Abuse and Mental Health Services Administration (SAMHSA) in its National Behavioral Health Quality Framework states, "The phrase 'behavioral health' is used to describe service systems that encompass prevention and promotion of emotional health; prevention of mental health and substance use disorders, substance use and related problems; treatments and services for mental and substance use disorders; and recovery support." (https://www.samhsa.gov/data/national-behavioral-health-quality-framework#overview) In the context of primary care, behavioral health services can also support behavior change related to chronic health conditions.

[1]*Substance Abuse and Mental Health Services Administration. (2017). Prevention of substance abuse and mental illness. Retrieved from https://www.samhsa.gov/prevention*

According to the results from the 2014 National Survey on Drug Use and Health (NSDUH), 43.6 million, or one in five, adults and 2.8 million adolescents aged 12 to 17, had a mental illness.[2] Of those adults that have had a mental illness within the last year, it is estimated that only 14.4 percent received treatment.

Substance use disorders (SUDs) occur when the recurrent use of alcohol or other drugs (or both) causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. It is estimated that 21.5 million people ages 12 and older had a SUD in 2014. Approximately 3.8 million people aged 12 or older received substance abuse treatment within the past calendar year. This means that it is estimated that 17.7 million people did not receive treatment.

Co-occurring mental health issues and substance use disorders is referred to when a person has both a mental health issue and a substance use disorder. It is estimated that 7.9 million adults in the past year had both a mental health issue and a SUD.[3]

State impact of behavioral health conditions

In the Dakotas, as in the rest of the country, there is a significant gap between the incidence of behavioral health conditions and the number of individuals who receive treatment for those conditions.

According to the SAMHSA Behavioral Health Barometer report, from 2011 through 2015, only 39.5 percent of South Dakota adolescents aged 12-17 with a major depressive episode in the past year received treatment for depression. The corresponding figure in North Dakota was 48.6 percent. Among South Dakotans aged 18 and older with any mental illness (AMI) only 42.9 percent received treatment compared to 40.6 percent of North Dakotans.[4] More than 65 percent of rural Americans get their mental health care from their primary care provider.[5]

The limited access to behavioral health treatment and services is due in part to a shortage of behavioral health providers particularly in the rural parts of North Dakota and South Dakota. As illustrated in the maps below, most counties in both North Dakota and South Dakota are designated as Health Professional Shortage Areas for mental health services.

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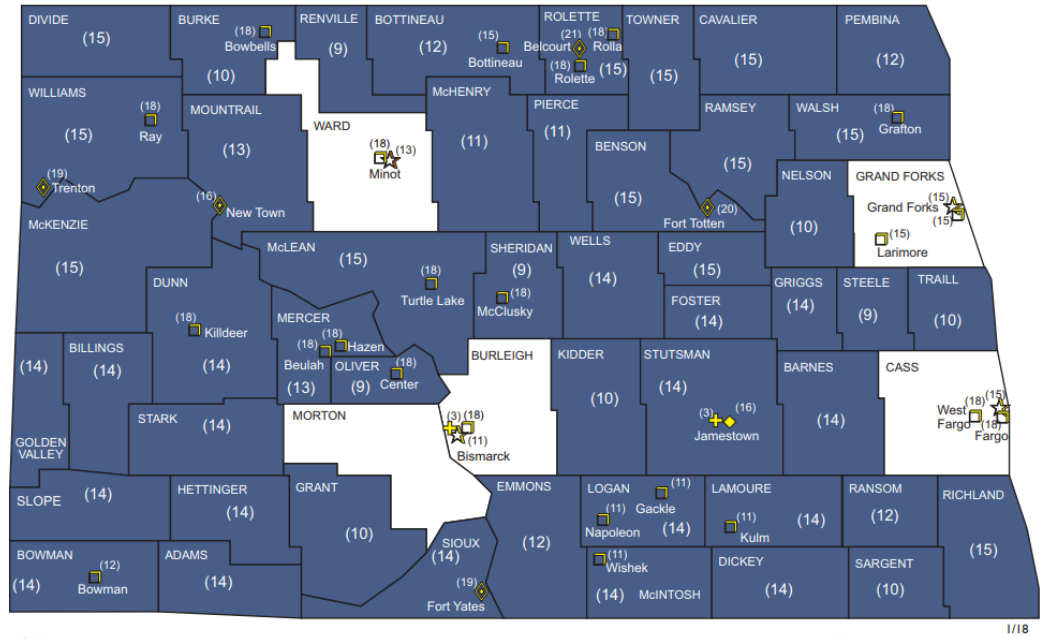
[2]Any mental illness (AMI) is defined as having any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria, excluding developmental disorders and substance use disorders.

[3]Substance Abuse and Mental Health Services Administration. (2017). Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health National Survey of Substance Abuse Treatment Services. Retrieved from https://store.samhsa.gov/shin/content//SMA17-BAROUS-16/SMA17-BAROUS-16.pdf

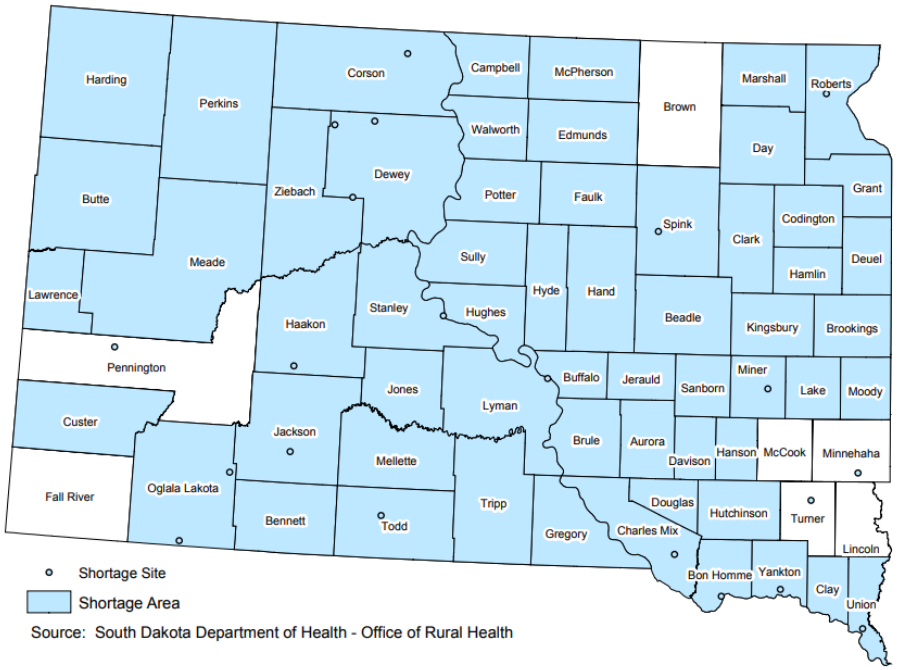
[4]Substance Abuse and Mental Health Services Administration. (2017). Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health National Survey of Substance Abuse Treatment Services. Retrieved from https://store.samhsa.gov/shin/content//SMA17-BAROUS-16/SMA17-BAROUS-16.pdf

[5]American Psychiatric Association. (2017) National Recovery Month 2017: Focusing on Access to Care in Rural Areas. Retrieved from https://www.psychiatry.org/news-room/apa-blogs/apa-blog/2017/09/national-recovery-month-2017-focusing-on-access-to-care-in-rural-areas

North Dakota Mental Health Professional Shortage Areas



SOUTH DAKOTA HEALTH PROFESSIONAL SHORTAGE AREAS
MENTAL HEALTHCARE
January 2018



Source: South Dakota Department of Health - Office of Rural Health

Role of community health centers in providing behavioral health services

Historically, there has been a tendency to separate behavioral health services from physical health, resulting in separate service locations. Both North Dakota and South Dakota have community mental health systems that are funded to provide behavioral health services to low-income and underserved populations.

In recent years, there has been a growing body of evidence to support the integration of behavioral health and primary care.[6] As a result, primary care providers have been offering a growing number of behavioral health services and community mental health providers have been adding physical health services and providers. Regardless of how partnerships develop, there is a recognition that the divide between primary care and behavioral health services must be bridged. The connection between CHC and community mental health centers is a natural one, because they often serve similar populations. While CHAD envisions a future that includes an expanded number of behavioral health services at CHCs, we do not see that expansion coming at the expense of the community mental health system.

We recognize the importance of that system and the fact that it is already underfunded. Rather than fighting over a pie that is already too small, we hope to work with behavioral health advocates to increase the investment in behavioral health services so that primary care, particularly through CHCs, can effectively, using an evidence-based approach, take on an appropriate role in meeting the behavioral health needs of the patients it serves.

Behavioral health is one of the core required services that all Community Health Centers must provide, either directly or through contractual arrangements. According to the Bureau of Primary Health Care (BPHC), these services can be provided through different service delivery methods including direct or a formal written contract/agreement, such as referrals to outside providers and services. All nine community health centers in the Dakotas received funding from the BPHC in 2017 to expand their behavioral health services and more emphasis and resources are expected from BPHC in this area in the months and years to come.

CHCs across the Dakotas deal with behavioral health conditions in their patients every day. Nearly a quarter of the patients we serve in both states have been diagnosed with a mental health or substance abuse condition, including 17,139 patients in South Dakota and 11,024 patients in North Dakota during 2017.

Across the country, the majority of behavioral health services are now provided in primary care,[7] and CHCs in the Dakotas are part of that trend. Services provided at CHCs in the Dakotas include:

- Screening for depression, anxiety, suicide, and substance abuse;
- Behavioral health counseling services, including mental health and substance abuse services;
- Tobacco cessation counseling services;
- Support for changes in health behaviors including managing chronic health conditions and meeting health and wellness goals;
- Brief intervention appropriate to the primary care setting;
- Medication assisted treatment (MAT) which includes visits with a primary care provider and a collaborating behavioral health specialist to address chronic opioid and/or alcohol abuse;
- Child behavioral health services including partnerships with local schools; and
- Behavioral health services offered through telehealth to remote and rural communities.
- In addition, CHCs refer patients to more intensive specialty treatment when warranted. Ideally, those referrals take place in the context of collaborative partnerships that recognize that behavioral health and physical health are interconnected.

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[6] Patient-Centered Primary Care Collaborative. (2018). Benefits of integration of behavioral health. Retrieved from https://www.pcpcc.org/content/benefits-integration-behavioral-health

[7] National Association of Community Health Centers, Inc. (2004). Health centers' role in addressing the behavioral health needs of the medically underserved. Retrieved from http://www.nachc.org/wp-content/uploads/2015/06/BHReport04.pdf

One data point that demonstrates the growth in engagement among CHCs in the Dakotas relative to behavioral health services is a positive three year trend on the UDS "clinical depression screening and follow-up plan" measure. In North Dakota there was an increase from 70.1 percent to 81.0 percent of patients who were screened for depression and had a follow-up plan between 2014 and 2016. In South Dakota, the percent who were screened and had a follow-up plan rose from 47.6 percent to 62.6 percent during that same period.

Behavioral Health Integration and Brief Intervention Services

Clinical trials have demonstrated that when a patient has a behavioral health problem and one or more physical health problems, integrated care can be more effective than traditional treatment delivery.[8] Many community health centers have set the goal of moving up the scale of integration between primary care and behavioral health, by building partnerships with behavioral health providers, offering co-located services, and more effectively sharing information about physical and behavioral health conditions.

When looking at behavioral health integration options, the use of screening, brief intervention and referral to treatment (SBIRT) has been identified by community health centers in the Dakotas as a very promising practice. While the SBIRT model was originally designed and tested with a population with alcohol, tobacco and substance misuse, it is also being applied in many health center settings across the country to address a range of behavioral health concerns. SAMSHA defines the SBIRT model to include the following characteristics:

- It is brief. (The initial screening is accomplished quickly and the intervention and treatment components indicated by the screening results are completed in significantly less time than traditional specialty care.)
- The screening is universal.
- One or more specific behaviors are targeted.
- The services occur in a public health non-behavioral health specialty setting.
- It is comprehensive. (The program includes a seamless transition between brief universal screening, a brief intervention and/or brief treatment, and referral to specialty care.)
- Strong research or experiential evidence supports the model's effectiveness.[9]

While SBIRT is a very promising practice, its implementation would require a significant commitment to process transformation and training from community health centers. As such, they have requested training relative to: brief intervention methods for behavioral health providers who may have been trained in more traditional modes of behavioral health care; process flow and how to integrate brief intervention into the life of a primary care practice; and ways to make the model financially sustainable.

CHAD supports adequate reimbursement of SBIRT services along with the support needed for traditional primary care and behavioral health programs to transition to full adoption of an SBIRT model for those CHCs that choose to modify their approach.

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[8] Substance Abuse and Mental Health Services Administration. (2018). What is integrated care? Retrieved from https://www.integration.samhsa.gov/about-us/what-is-integrated-care

[9] SAMHSA (2011). Screening, brief intervention and referral to treatment (SBIRT) in behavioral health care. Retrieved from https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf

Substance Abuse Treatment Program/Medication Assisted Treatment (MAT)

Substance abuse treatment, like mental health treatment, can be effectively integrated into primary care. In a paper commissioned by SAMHSA and HRSA, the Center for Integrated Health Solutions notes:

> Clinical trials have demonstrated that when someone has a substance abuse problem and one or more non-substance-related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost.[10] It results in better health outcomes for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care.[11] [12]

Primary care providers can screen for problematic substance abuse behaviors, conduct assessments, support behavioral change, conduct SUD counseling, and generally help manage chronic SUD conditions in the primary care setting. They are also well-suited to provide medication assisted treatment (MAT). MAT typically includes prescription medications that support management of opioid abuse and alcoholism along with supportive services that can include counseling and case management services. Of course, the use of medication to support management of a nicotine addiction is widely practiced in primary care and – while typically not included when MAT is discussed – is a great example of the efficacy of using medication to support patients with a substance addiction.

In both North Dakota and South Dakota, similar to much of the country, individuals with SUD have limited access to MAT. According a recent report, only about half of counties in the United States have a provider with a waiver to prescribe buprenorphine; 60.1% of rural counties have no waivered providers. The majority of both North Dakota and South Dakota counties have no waivered providers.[13] According to SAMHSA's current map of certified MAT prescribers, there are currently 41 certified providers for MAT in North Dakota. In South Dakota, there are currently 32 prescribing MAT providers.[14] As of spring 2018, 3 of the 9 CHCs in the Dakotas provide MAT services.

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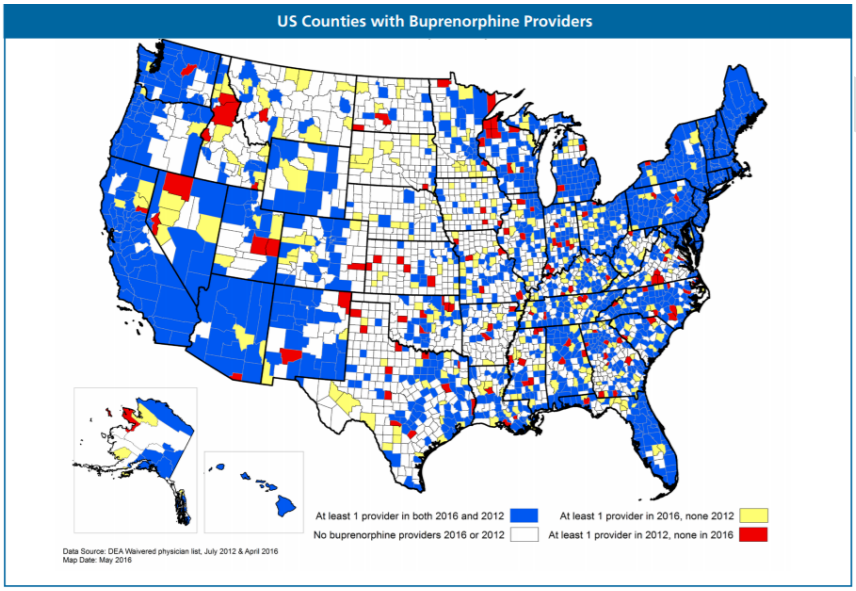
[10] Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization and cost impact of integrating substance abuse treatment and primary care. Medical care, 41(3), 357-367.

[11] Oslin, D.W., Grantham, S., Coakley, E., Maxwell, J. Miles, K., Ware, J., et al. (2006). Prism-e: Comparison of Integrated Care and Enhanced Specialty Referral in Managing At-risk Alcohol Use. Psychc servs, 57(7), 954–958.

[12] SAMHSA-HRSA Center for Integrated Health Solutions. (2013). Innovations in addictions treatment: addiction treatment providers working with integrated primary care services. Retrieved from https://www.integration.samhsa.gov/clinical-practice/13_May_CIHS_Innovations.pdf

[13] Andrilla CHA, Coulthard C, Larson EH. Changes in the Supply of Physicians with a DEA DATA Waiver to Prescribe Buprenorphine for Opioid Use Disorder. Data Brief #162. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, May 2017.

[14] Substance Abuse and Mental Health Services Administration. (2018). Buprenorphine treatment practitioner locator. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=SD&page=1



CHAD supports adequate reimbursement for SUD treatment services that are appropriate to the primary care setting, including MAT. Adequate training to support these services is also needed.

Peer Support Specialist

Given the workforce shortages identified above, consideration should be given to how peer support specialists can be supported to extend the reach of the behavioral health workforce. A peer support specialist is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services. Peer support is an evidenced-based practice that improves quality of life, increases patient engagement and self-management, and increases whole health. As of January 2017, 40 states and the District of Columbia have established programs to train and certify peer specialists. Recently, states have begun to utilize peer support in integrated settings and has been shown to be an effective tool in whole health management for individuals with behavioral health conditions.

North Dakota has already begun to recognize the potential impact of peer support specialists through an innovative program designed for individuals who are recently incarcerated. Free Through Recovery is a community-based behavioral health program designed to increase recovery support services to individuals involved with the criminal justice system who have behavioral health concerns. These participants work with local providers to receive care coordination, recovery services and peer support. This type of innovative approach should be contemplated and supported as one way to expand the capacity of our current behavioral health system.

Telehealth

Telehealth has been shown to be an effective tool for providing behavioral health services. It is just as effective as face-to-face intervention.[15] Community health centers in the Dakotas have used telehealth to deliver high quality behavioral health services, particularly to support access to care in rural and frontier communities that may lack an adequate behavioral health workforce.

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[15] Substance Abuse and Mental Health Services Administration. (2016). Rural behavioral health: Telehealth challenges and opportunities. Retrieved from https://store.samhsa.gov/shin/content/SMA16-4989/SMA16-4989.pdf

Despite the growing consensus about the efficacy of using telehealth to expand access to health care services, community health centers face a complex array of regulations and reimbursement policies that are a barrier to widespread adoption of telehealth. HRSA should provide additional and supportive guidance about how FTCA rules, Medicare reimbursement rules, and the fee schedule guidance should be interpreted.

The non-financial barriers to providing telehealth services should be eliminated and then adequate reimbursement for telehealth in state, federal, and private health plans should be adopted. The cost of services at both the originating and distant sites should be adequately reimbursed. In addition, community health centers need support for the connectivity and technology needed to support telehealth services.

Suicide Prevention

Individuals in the Dakotas face a significant risk of death by suicide with South Dakota ranked 13th and North Dakota ranked 16th nationwide in number of deaths per population by suicide. A recent study found that 64 percent of people who attempt suicide have visited a doctor in the month before their attempt, and 38 percent in the week before,[16] which reinforces the need for a primary care workforce that is attuned to and regularly screening for suicide risk. Community health centers are able to identify patients with a risk of suicide and intervene in order to prevent suicide deaths among their patients.

Include CHCs in suicide prevention work, including funding for prevention, screening, and intervention.

CHAD Recommendations

Address major funding shortages for behavioral health services by providing adequate Medicaid reimbursement for CHCs that are developing behavioral health programs. Medicaid programs should cover:

- Mental health and substance abuse treatment counseling services;
- Mental health and substance abuse treatment group visits;
- Mental health and substance abuse treatment assessments;
- Coverage for services provided by all qualified behavioral health providers; and
- Reimbursement for evidence-based brief intervention programs.
- We encourage the addition of certified peer support services as a benefit to the North Dakota Medicaid program, and
- We support South Dakota's current effort to add a substance abuse treatment benefit to the Medicaid program and encourage them to work with CHCs to ensure that the care provided within CHCs is adequately reimbursed without unhelpful barriers to care.

Support expanded eligibility for Medicaid as an important way to improve access to behavioral health services.

- We applaud North Dakota for expanding eligibility for Medicaid to individuals with incomes up to 133% of the federal poverty level because this enables a population that tends to have a high need for behavioral health services to get access to needed services. We encourage North Dakota to continue to fund its Medicaid expansion and call on South Dakota to similarly expand access to Medicaid coverage for low-income South Dakotans.

[16] Ahmedani, Brian K. "Racial/Ethnic Differences in Health Care Visits Made Before Suicide Attempt Across the United States." Medical Care 53.5 (May 2015): 430-35. Web.

Address workforce shortages by supporting the following:

- Reduce the barriers for qualified professionals to become licensed in the Dakotas, including support for recognizing licenses across state lines;
- Enhance access to in-state behavioral health professional training programs;
- Consider enhanced professional training and certification options as opposed to maintaining strict barriers between the services various behavioral health providers can offer;
- Support North Dakota's current effort to expand the available behavioral health workforce by developing peer support services; and
- Support access to coverage for behavioral health services through enforcement of mental health parity laws and increased access to coverage through public and private sources. We recognize that a shortage of professionals can develop when there are not enough individuals who have access to adequate behavioral health coverage.

Support payment for telehealth as a way to increase access to behavioral health services in rural and frontier communities.

- We support adequate reimbursement for telehealth in state, federal, and private health plans. When both originating and distant sites are required, the cost of services at both locations should be adequately reimbursed.
- Regulatory barriers to providing telehealth services should be reduced.
- Community health centers need support for the connectivity and technology needed to support telehealth services.

Enable wider adoption of Screening, Brief Intervention, and Referral to Treatment Services (SBIRT) by:

- Providing training on SBIRT methods; and
- Supporting the sustainability of SBIRT through adequate reimbursement of brief intervention services in primary care.

Support adequate reimbursement for medication assisted treatment (MAT) services in primary care.

Include CHCs in suicide prevention work, including funding for prevention, screening, and intervention.

In this document, unless otherwise noted, the term "community health center" is used to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended (referred to as "grantees") and FQHC Look-Alike organizations, which meet all the Health Center Program requirements but do not receive Health Center Program grants. It does not refer to FQHCs that are sponsored by tribal or Urban Indian Health Organizations, except for those that receive Health Center Program grants.

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