Danielle Durant: Good afternoon, everyone. I'm Dr. Danielle Durant, a principal research associate for Westat and director of the Agency for Healthcare Research and Quality's Academy for Integrating Behavioral Health and Primary Care. I am so happy to welcome you to our panel discussion, Integrated Behavioral Health: The Journey to Becoming the Standard of Care.

So AHRQ created the Academy to respond to the recognized need for a national resource and coordinating center for those interested in behavioral health and primary care integration. And so, the Academy organizes the knowledge base and research and expert insight on why and how to integrate effectively and on a meaningful scale. And this work is guided by our technical expert panel, the National Integration Academy Council, or NIAC, as you may hear them being referred to as.

And today's event features several members of that council, some serving on our formal panel and some here that are here to offer their comments and insights. And you can learn more about the work of the Academy by visiting integrationacademy.ahrq.gov. I'm now going to turn today's event over to our moderator, Dr. Garrett Moran, who serves as the principal investigator for the AHRQ Academy.

Dr. Moran is going to briefly set the stage, introduce our panelists, and then facilitate the discussion, which will include time for audience questions. So if you would like to ask a question today, please do so by entering it into the Q&A box. Okay. Dr. Moran, the floor is yours.

Garrett Moran: Thank you, Danielle. So delighted to have you all here today. It's clear that we have a nice-sized group, and I hope it will be an interesting and informative discussion about a very important topic. What do we mean when we talk about integrated care? And the best definition is one that was developed by one of our speakers in partnership with other members of the NIAC, Dr. Peek, and I'll introduce all of them in a minute.

But that definition reads that integrated behavioral health is a practice 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 use conditions, health behaviors, including their contribution to chronic medical illnesses, life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.

In our panel today, we're going to start off with a bit of the background and history of the development of behavioral health integration to today, then we're going to have some speakers who are actively involved in implementing behavioral health integration in a variety of settings, a discussion of the policy issues, and we'll be talking both about experience with implementation, some of the challenges that we've encountered along the way, and what needs to happen going forward to really completely succeed in making integrated care the standard of care for healthcare in America.

Our speakers today include Dr. C.J. Peek. Dr. Peek is a professor of family medicine and community health at the University of Minnesota. C.J., wave. He's also the one with the tie. Dr. Steve DiGiovanni is medical director for the Maine Medical Center Outpatient Clinics and medical lead for the MaineHealth Adverse Childhood Experiences and Resiliency Program, and he'll be telling us more about that, Steve.

Dr. Stacy Ogbeide is associate professor of family and community medicine and director of the primary care track coordinator for the Clinical Psychology Internship Program at the Department of Family and Community Medicine at UT Health San Antonio. I didn't realize you had those palm trees in the beach in San Antonio, Stacy. And Dr. Alexander "Sandy" Blount is a professor emeritus of family medicine and community health at the UMass Chan Medical School, where he founded the Center for Integrated Primary Care.

Finally, last but not least, Dr. Beth McGinty is the Livingston Farrand Professor of Public Health and chief of the Division of Health Policy and Economics in the Department of Population Health Sciences at Weill Cornell Medical College. So with that brief introduction, I'm going to turn it over to Dr. Peek to give us a bit of the background and history of the development of integrated care to the current day. C.J.

CJ Peek: Well, thanks, Garrett. Looking back, you see a developmental trajectory for this field. It's a 40-year story of recognizing a problem, mobilizing the energy to change things, channeling all that energy constructively, and then taking it mainstream to get widespread implementation. So if you go back to the '80s and '90s, it was the first era. It was raising consciousness of the need for change. Care was fragmented along a way-too-distinct medical-mental health boundary. It was like a mind-body problem in healthcare.

Care was fragmented along the gulf between separate and parallel systems for care delivery. Two kinds of problems, two kinds of clinics, two kinds of clinicians, two kinds of covered benefits, and people falling through the cracks. So this did not match reality. Famous studies by Rodger revealed that, and this is what one of the titles was, primary care is the de facto mental health system in the U.S.

This showed that that's where people bring their problems, and this shook people up, because it's like we're not designed for a reality where people bring their mental health problems with them to primary care. We're missing the boat and have to change. That was really important. At the same time, there was new literature on the interrelatedness of everything, the biopsychosocial model of health and care, and the place of family systems, and also thinking of health organizations systemically as having parts that need to be integrated as well.

And so, these were very important things in the background. The developmental challenge was to recognize the huge problems of fragmented care along the mind-body split, and then mobilize the data and the motivation to change things, not only in how care works, but how clinics work. This was the era of why. Why be different? So the consciousness was raised by 2000, and I think of it as the second era now.

There were a lot of efforts, not just legendary exemplars that were visible in the '80s and '90s. There was an explosion of interest and enthusiasm as these realities sank in and the need for change. The thing was that at that time, everybody had a different idea of what the heck is integration. And so, the enthusiasm exceeded the level of shared definition and basic concepts in the field. It's an emerging field, not to apologize for it, but it is an emerging field and in need of being built up, and in order to get our act together rather than being seen by business and policymakers as energetic but all over the place.

So at the same time, there were research studies from NIMH that were revealing the limits of disease-oriented thinking, traditional ideas of you get a narrow intervention for depression, for example, because the actual clinical context in primary care were full of patients with multiple conditions and all kinds of life situations, and the clinics themselves had all different kinds of capabilities.

So the research shifted from single intervention on one condition to what's the effectiveness in the real world of actual clinics and patients that have all kinds of conditions and situations. So this literature also amplified the complexity of it all. The developmental challenge was to, let's say, channel all this exploding enthusiasm into constructive, shared work to build this new field together while, at the same time, accepting that it's a huge and complex systemic challenge, not only clinically, but organizationally, and certainly for research.

So this was a big challenge, a lot of enthusiasm and an increasingly obviously complex task. At this stage, the AHRQ Integration Academy was founded. With its national expert panel, its job was to help coalesce all this energy, and do so with many products, such as a curated literature collection, a consensus functional definition, what the heck is integrated behavioral health anyway, an online playbook for how to go about it.

Okay. So now, the third era is now, and that's the challenge, is to go mainstream, how to get widespread implementation on a meaningful scale. The question really has shifted from why... People don't really question that anymore, but why to how. So position papers came out, urging this as the standard of care, but the challenge of widespread implementation remains. It is still in pockets.

The huge matter of how to implement anything has emerged, hence implementation science and the ideas of learning health system have entered the picture. But also, it has become a huge challenge of new business models and policy that actually support the functions of integrated behavioral health that are not founded in the old separate and parallel, obsolete system of thinking that we left behind clinically. So this policy framework is required, a new one, to give a tailwind instead of the customary stiff headwind that programs encounter. So that's where the other panelists will pick up. Back to you, Garrett.

Garrett Moran: Very good, C.J. So it really has been interesting. Despite my youthful appearance, I'm old enough to have lived through all those phases. And I started off working in the specialty healthcare system, did that for several decades. I was a state behavioral health commissioner, and then I had the opportunity to be the director of the writing and consultant support team for the president's New Freedom Commission in about 2003.

And I saw Jürgen Unützer's paper on the interface of general medical care and mental health, and it just was like a light bulb that was like, "Wow, this is what we need to be doing." And I started making it a priority to move in that direction, and the development of the Academy was my first opportunity to really take that and run with it.

So I've been working with the Academy since its inception, and I'm really committed to doing whatever we can to move this forward. I want to turn it over to Dr. Stephen DiGiovanni from MaineHealth. He's going to tell us about his experience implementing integrated behavioral healthcare in a pediatric care setting in Maine. Steve.

Steve DiGiovanni: All right. Thank you, Garrett, and thank you for mentioning the pediatric viewpoint. And that's just one of my most exciting parts of this in that we only have a certain developmental window to really allow children to achieve their best developmental and behavioral health goals. And one of my major goals is I'm handing over a child to adult health, and how do we get to a place of truly supporting families and allowing children to thrive?

One, I'm just blessed to work in a health system that has a foundational belief in the importance of integrated behavioral health. There are pioneers and leaders at our health system that set us on this trajectory, and I'm utterly appreciative of their efforts and success. And so, at this point, we do have invested integrated behavioral health model with licensed clinical social workers in all of our primary care sites, pediatrics, family med, adult medicine, and also many of our specialty sites.

Personally, my work with the behavioral health clinician has completely altered the trajectory of my care, my teaching, and my career, and of which I'm truly thankful. And I would kind of sum it up that really now, as a teacher, a clinician, and a leader, I try to pause before each interaction and think, "Where and how are we going to support the family in front of us or the families that we take care of so that they can help their children to achieve their best behavioral and developmental health?"

And so, it's just that little pause before every visit. It doesn't matter if the patient's coming in with any type of issue, whether it's a sleep problem or asthma. That still is a core component of every visit. My first message is that investing in, I think, behavioral health is important, but there's ways to do it that I think can truly change the culture of the medical community and organizations that will best impact the outcomes for patients.

What's helped us an amazing amount is, for our ACEs and Resiliency Project, we have a dual-led model, so myself on the medical side and then Stacey Ouellette, the director of integrated behavioral health. And so, a true co-led model where we collaboratively develop the workflows, the trainings, and every step of the way, trying to truly remove the walls between medical and behavioral health, and really referencing it just as well for pediatrics health and development.

It helped immensely in getting buy-in from leadership and practices, because when we can present together, we're bringing different skills, different knowledges, and showing how this can be achieved. And then as I said, we developed the trainings, workflows, our electronic medical records and data together to make sure that they align between the medical health and behavioral health arms of our organization.

There's a few foundations to our approach. The number one is that this is a trauma-informed approach, and it really has impacted our staff, number one, in making sure that they feel safe and supported, and the same for our patients. Number two is, we talk constantly about a two-generation, whole-family approach, that we're supporting the parents as much as we're supporting the children, and really breaking down walls to billing for that, and also to just kind of making sure that that is a foundational aspect of everything we do in pediatrics.

For our trainings, we offer general education to the entire staff, and then more specific trainings to the behavioral health clinicians to support what they're going to be doing for interventions, and then for the medical pediatric providers. We develop nice, standard workflows. We've used a lot of screening tools, a screening and response model to allow us to expand what we're doing, expand our skill sets, identify issues, whether it's developmental or behavioral health or other risk- and adversity-related issues, and then making sure we're responding.

A lot of outreach to our community partners, knowing that we can't do this alone. That helps with buy-in immensely, because if a physician or a provider feels like they're out on an island, frequently, you'll get resistance to wanting to take on the whole behavioral health model. Finally, we developed electronic medical records and data reports that kind of took our workflows, made sure education was built in there, that we're able to enter the information and track it, and then report it out, not just in how we're doing, but what are we identifying? The number of children who've experienced trauma, the number of children who have depression or suicidality, and what our response is.

So just to give an example, we use this model for pediatric trauma and PTSD screening and response, which was pretty new to pediatrics. By having an integrated behavioral health co-led model, we were able to get buy-in. It allowed us to start to screen for traumatic events, train the medical providers how to briefly respond in a resiliency-building manner, and then we were able to train our integrated behavioral health clinicians on PTSD symptomology response from birth all the way through 18 years of age.

And the other thing that we love emphasizing is that kind of one-stop shop, let's handle the situation right when it's in front of us. So a big emphasis on warm handoffs and that collaborative model, bringing the behavioral health clinician right into the room when the symptomology is identified, and just presenting them as the expert who's going to help us move forward.

We were able to use data reports, and a very positive response from the medical providers to then look for expansion. So this program started with one practice, quickly went to five in the Greater Portland area here in Maine. And then over the next three years, we spread it to 53 practices across the entire state. Very strong positive feedback on the integrated model component of this. The biggest feedback you get is, "Can we have more?" as there continues to be a behavioral health kind of crisis in the state, as I'm sure many other places have it.

The few things that we're looking to improve, one, showing outcomes. So, like for our depression screening and response, trying to track the PHQ levels over time, making sure that our behavioral health clinicians and medical providers are using it consistently. We use further strengthening of our registries to make sure children and families don't fall through the cracks that exist in our medical health system, and then advocating for additional case management supports and parenting supports, especially for the youngest children, when most of the brain development is occurring in those first five years. That is a bigger struggle. There's not a real way at this point to bill and support that level program.

So that's probably our biggest pivot, is to blend in case management with support for social drivers of health barriers and parenting to support attachment and development, and that's the direction we're going, aligning that with our behavioral health clinicians. Hopefully, that was kind of helpful of where we've been, where we're going, and really how excited we are.

Garrett Moran: Thank you, Steve. It is a very exciting program, I think, and I'm so glad to hear you talk about the use of data and measurement-based care, quality improvement, which is a key to every effective program. So now I'm going to turn it over to Dr. Stacy Ogbeide, who will tell us about the work she's doing in Texas and how the integration effort is coming there. Stacy.

Stacy Ogbeide: Thank you so much. Lovely to at least see you all, see your names listed here in the chat and in the Zoom. One of the pieces that I'll be focusing on over the next few minutes is where I live and breathe, which is workforce development issues. And I always get excited when I hear about integrated care, integrated behavioral health. It needs to be the standard of care. I could not agree more.

And I'm sure for all of you who are here, you are also hopefully in agreement, hence why you're here signed into this webinar. But one of the issues to getting there is, we need people power to get there. And so, some of the work that myself and my colleagues have been doing over the past few years is looking at workforce development, researching, pre-licensure-level behavioral health learners in particular, about what is needed to do a few things.

One, to support their needs at their level of training. Two is, how do we get you all as potential field supervisors, clinical supervisors, preceptors to want to have a student or an intern, or a fellow, or someone work with you or that you supervise? And then three, the big piece, which is that gap between, "I've got my degree, and then I have this number of hours I need to get before I have the alphabet soup behind my name, but how do I get those hours when my state, or at least payers within my state, don't reimburse for learners in that post-licensure piece?"

And so, one of the things that I think, and I hope to hear later on from our policy expert here in the panel, is some behavioral health disciplines have made some strides with that. So I'm a health psychologist, so I'm going to pick on psychology just for a second that I think has done this well, which is, about 10-ish years ago, we had the, quote, unquote, "Intern Bill" that got passed in many, many states, where psychology interns, so that last step after they finish their four to five years of their doctoral training before they're fully, or at least finish their degree training, that last year of training, they can be reimbursed through Medicaid, where that wasn't there before.

So that really opened up training opportunities, specifically in primary care, whether that's a community health center, an FQHC, or really any primary care setting. And so, that was beautiful that that happened. We have not seen the same thing happening for our fellow LPC colleagues, our LMFT colleagues, our LCSW colleagues, where they finish their training, and then they're in this gap of getting that hours, those 1,500 to 2,000 hours, where they can't get reimbursed.

And so, what we've noticed in our HRSA training grant that we've had for a number of years now, where we train these master's students in particular in primary care settings. They love primary care, and they get to graduation, and it's like clockwork. Every year, it's, "I can't find a primary care physician, because they say they can't bill for us. What do I do?"

And so, they're asking us, "What do I do in the meantime? I need to get my hours. I need to pay bills." And so, there's this nebulous time where they take a position, many times not in primary care, if they can't find a position that is grant-funded usually, and then they try to work their way back into primary care. And what we find, at least from our research, is that those folks, it's harder for them to come back once they're away for those years.

And so, my hope is that through this discussion today, we can figure out some solutions to help with that. One of the newer bills that just got introduced just recently, weeks ago, again going back to the psychology folks, there's this multipronged effort to... We've capitalized, at least in the Medicaid front. What about Medicare?

And so, the act is called the Accelerating the Development of Advanced Psychology Trainees, the ADAPT Act, that was just introduced, where we could potentially get reimbursed for same thing interns and postdoctoral fellows, just like we do for Medicaid to get reimbursed for Medicare. So, again, TBD on what that will look like, how that will unfold. But the exciting piece is that we have at least a precedence for Medicaid. And hopefully, that will happen for Medicare.

And hopefully, that can set a trajectory for other behavioral health colleagues that we desperately need in primary care, our LPC colleagues, our LMFT colleagues, our LCSW colleagues, when they're getting those post-degree hours, that we can have something similar to what psychology has figured out to support workforce and the trainees in primary care. Hopefully, we can expand it to our other colleagues.

So that's where at least we are right now. And so, I look forward to seeing your questions about, what are you doing to support workforce development? What are you doing to support field supervisors and faculty who would be interested in serving students and learners in primary care? I could talk about this all day, but I won't. I will hand it back to our great moderator.

Garrett Moran: Thank you, Stacy. And continuing on that theme of workforce, workforce, of course, is the perpetual challenge, and we're always trying to figure out ways to deal with it. Sandy Blount, Dr. Blount has worked in workforce training for many decades, and still offers training courses in that area. So, Sandy, why don't you tell us a little bit about the general issues of integrating behavioral health and primary care and your work in that area? You're muted, Sandy.

Alexander Blount: It was so good that when you told me I was muted, I said, "Thank you," as if you would hear it. So starting over again. I guess I want to talk about taking this to scale. What are we facing if we were to make integrated primary care the standard of care, and what have we learned from the process so far? One of the things... I guess we've been working on this since the conversation changed from why should we do it to how to do it.

And one of the things we've learned is, it's an ongoing developmental process, not a one-time program implementation. It tends to be a bigger change than people expect at the beginning. PCPs are delighted to have somebody, a behavioral health clinician, to help them care for their patients with mental health and substance use needs, but they are often surprised at how much the conversation clinically in the site becomes enriched by behavioral health conversation in many areas of the care that they're providing.

And they change from the idea of, "Refer, and someday people will get service," to "Can we engage people with this service today? Can we offer them an intervention, some care, and engagement on the day that they're ready to talk to someone about the issues they bring?" For mental health people, it's a challenge. If you're trained in specialty mental health, you may not have yet had the training to deliver that targeted intervention on the same day to begin to make a difference for people and to build a relationship for a longer connection with people that will be episodic over the years, to help them grow and to engage them in the same way that they engage with primary care.

What you will learn is that you become so much better at working in a team than you have been in the past, and we mental health people become way more knowledgeable about chronic illness than we ever imagined we would be. But it doesn't seem to be possible to speed the development up dramatically, because you have to go through the steps. You have to learn how to do integration, and then you have to learn how to do it well, and then you have to learn how to do it efficiently.

And for most places, that's a three- to five-year process, clinically and administratively and fiscally. So the exemplars in this process, the ones we look at and say, "I want to be like them," they've been at it 20 years, 40 years, one's 60 years, and they have continued to develop and get better, and make processes smoother than some of us could have imagined just a few years ago.

So there are things, however, we can do to speed the process nationally, as national kinds of interventions. One is, train family physicians and pediatricians and nurse practitioners and physicians' assistants in integrated settings. People are much better at learning to work in teams when they're in training than when they have already set up practice patterns in their full-time jobs.

Another is, create... I'm totally supporting what Dr. Ogbeide said, that we need to create greater partnership between university credential programs and on-the-job programs in health systems, and those partnerships need to have a funding mechanism that keeps the work that's done by the trainees to be valued and become incentivized for the systems. We have to face the fact that because of this evolution that sites are involved in, that shared learning and training is ongoing, not just for the students or for new staff, but for everybody, and ongoing shared learning happens best in teams, and teams need to be supported financially.

Someone has to underwrite the time for people to talk with each other, to discuss patients, to talk about the data that they should be getting on their panel of patients, and the health and the experience of care of the people that that team is serving, and that this conversation needs to allow for piloting new approaches or making adjustments. When that happens, the evidence is very strong that it is much more fun and less stressed to work in primary care, and that there's a measurable increase in clinician retention, which, in the long run, makes team time actually pay off.

The evidence is clear that with high burdens of chronic illness and behavioral health conditions, that patients who have those kinds of burdens need a strength-based approach in order to be engaged in care and to stay in care. And so, we need to use training and AI, the new gift of AI, to help us write notes that our patients will read that are in strength-based language to help us use that kind of script in counseling our patients, whether we're medical or behavioral health.

We want to have some help in removing the patchwork of state regulations that will make something possible in one state and not in the next, that regulations, like, for instance, there can't be a medical billing and a behavioral health billing in the same site on the same day, which, essentially, effectively makes the best advantage of integration impossible.

And finally, we need to use funding approaches that incent integrated care. And a great example is, California has recently legislated that health plans give primary care practices a system to pay for behavioral health integration through the same mechanism that funds medical systems, not two parallel payment systems, not parity, but primary care as part of healthcare, as standards of primary care. And I will pass it back to you, Garrett.

Garrett Moran: Thank you, Sandy. And really great points about some of the challenges and complications we run into in trying to move this forward, and we're also getting some really good questions here. Please feel free to submit your questions in the Q&A box, and we will get to them in a few minutes. But I want to turn next to Dr. Beth McGinty, who's going to focus specifically on the policy issues, what's developed over the last several years, and what needs to develop going forward. And so, Beth, tell us all about that.

Beth McGinty: Yeah. Thanks so much. It's great to have the chance to engage with everybody today, and thanks to my fellow panelists for teeing up so many policy issues. I am not going to be able to hit on all of them. There are a myriad policy issues that we could discuss this afternoon, and happy to go in various directions during discussion.

I am going to focus here on payment policies, which is consistent with some of the issues that you have heard. I'm making that focus because that is where a lot of the action over the past decades have been, and it's also where we need some further action. That is not to say that there aren't other important policy domains. I could also talk about graduate medical education accreditation policies and other kinds of things. But I'm going to focus in my brief remarks here on the payment policy front.

And I am going to go through three buckets and tell you a little bit about issues and progress and future directions. So first, and this is really, I suppose, a bit of a predecessor to payment policy, is insurance coverage of integrated care. Right? Are you covering it at all, which means you're paying for it, but forget about how you're paying for it or how well you're paying for it? Just, are you covering it?

So historically, this has been a real barrier for integrated care. There weren't, 20 years ago, any billing codes where a provider could bill an insurer for a, quote, "integrated care service." And what do I mean by that? I mean a care coordination service or an initial assessment to figure out whether somebody needs behavioral health integration by a primary care provider. All of the things that providers do to integrate care that are not a direct clinical billable service involves phone calls. It involves looking at data. It involves tracking your patient panel, all of the things you've heard about from our group of panelists.

So we have had some progress there. There is more progress to be made, but we've had some. A key policy innovation here was that the Centers for Medicare & Medicaid Services, CMS, introduced behavioral health integration billing codes in 2017 in Medicare. And these codes, in a nutshell, probably at least some of our audience members are familiar with them, they allow billing of exactly the kinds of integration services that I just alluded to.

I'm not going to get in the weeds on these codes, but broadly, there are two buckets of them. One bucket is collaborative care model billing codes. And so, for those codes, you have to be a practice that is implementing the collaborative care model, where you have a primary care provider who is working with a psychiatric consultant and a behavioral healthcare manager to implement measurement-based care and the other structures and processes of the collaborative care model.

And then there are also general behavioral health integration billing codes, which do not require that full collaborative care model, which can be quite hard for particularly smaller practices to implement to be in place. And so, those can be billed in the context of a single primary care provider who is doing a behavioral health integration service.

These billing codes provide pretty modest reimbursement. Just to give you a flavor, I looked at the physician fee schedule, you can look this up online, for Medicare. Depends on what area of the country you're in, because there's geographic adjustments. But the average reimbursement here is, for somebody who is billing for the first month of integrated care in the collaborative care model for a patient and has 70 minutes of integration activities in that model, it's about a $150 reimbursement. For somebody who is billing for 20 minutes of a general behavioral health integration service outside the collaborative care model, it's about $50 reimbursement. So we're not talking about big box here.

These codes are a step in the right direction. They exist in Medicare. They have been adopted by some, but not all, Medicaid programs and commercial insurers. So that is an area for improvement. It's very challenging. Providers see patients with many different insurers. Right? And so, you can bill for this for some insurers, but not others. There are also some challenges that have been raised with the codes that could be addressed through policy refinement, including the fact that the way they're structured, it's a one-sided payment, where the entire payment flows to the billing primary care provider.

And so, that means it places administrative burden on primary care providers to set up contractual arrangements if the psychiatric consultant is outside of the practice, or even when someone is co-located but in a different division, like ledger transfers. There's a lot of administrative costs or burdens. So I'll stop babbling on about billing codes. That was number one.

Number two is alternative payment models. And in a nutshell, alternative payment models are models that get us out of this fee-for-service billing structure, and that try to incentivize more high-value care. So this, at a high level, is something like a global budget, which some states, Maryland has really been a leader here, are starting to adopt, where rather than getting a fee for every service, you are operating under some kind of global budget, where you get a certain prospective payment that's risk-adjusted for your patient pool, and then you are held financially responsible to control costs within a certain limit and meet certain quality benchmarks.

And that sort of model, there's a big new CMMI, Centers for Medicare & Medicaid Innovation Services, demonstration project taking off called AHEAD, which is meant to really test this out in many states. That sort of model could incentivize behavioral health integration in that behavioral health integration is consistent with many of the goals in terms of improving whole-person healthcare and being accountable to outcomes for a population.

There are a bunch of challenges there in some related models, like accountable care organizations. We haven't seen much progress here, in part because we don't have great metrics for behavioral health integration that we can incentivize organizations to meet. So that is an area where there's a lot of action, and I think many more things to be learned.

And then finally, I will flag, sometimes we need to put new policies in place. Sometimes we need to remove problematic policies around integration. And one policy that's quite problematic, and has been around for ages, and we still haven't totally managed to get rid of, is a same-day billing prohibition in Medicaid. I won't go through the entire legislative history here, but there was some federal law that had been interpreted by Medicaid programs as saying that primary care providers cannot bill for a behavioral health service and another kind of medical service on the same day, which is a very obvious barrier to delivering integrated care.

That was clarified by the federal government in the 21st Century Cures Act in 2016, that actually, federal law is not prohibiting same-day billing. So this clarification happened at the federal level. However, as is often the case, federal rules get codified into state laws. And so, a bunch of states had repeated, in their state law, you cannot do same-day billing.

And so, that still exists in... We actually don't know exactly how many states, but about half is the most recent, rigorous estimate that are either still have a state law on the books, or the state Medicaid agency is still interpreting that federal law saying that you can't do same-day billing. So that is a case where we really need to remove that barrier and be consistent with the federal law as it is meant to be interpreted. So I'll stop there.

Garrett Moran: Well, I'm going to probe you just a little bit more. A clearly related issue is just the general inadequacy of funding for primary care, and I know the current administration and CMS is talking about some changes there. I'm springing this on you a little bit, Beth, but can you tell us a little bit about what's underway there and how promising it looks?

Beth McGinty: Yeah. I mean, it would broaden this a little bit to payment for behavioral health too, which is also low and is a challenge here. So primary care and behavioral health are often reimbursed at lower rates than services for other specialties. There's a whole host of reasons for that. That's a whole other lecture. But yeah, there's a lot of activity to try to increase funding around primary care and behavioral health through a whole variety of policy mechanisms.

I am not in the weeds on the federal primary care proposals on the behavioral health side. Actually, this past year, in the physician fee schedule for Medicare, there were some modest increases, and there's a lot of action in Medicaid with state-directed payment mechanisms in particular, where state Medicaid agencies are directing their Medicaid managed care organizations to increase provider reimbursement rates around behavioral health.

Garrett Moran: Very good. We've got some great questions from the audience, and maybe we should just dive into those. We're already down to not having a ton of time left over. Danielle has asked me to be sure and remind you that this is being recorded, and the video will be available on the Academy website within a couple of weeks at the latest, maybe a little sooner.

So the first question is from Marie Stout. It says, "Can you please share more thoughts on the state of integrated care specific to substance use disorders and what is still needed?" And I'll just say that that is one of the major focus areas of the Academy, particularly over the past five, seven years, addressing the opioid epidemic. And we do have a playbook specifically on the implementation of medications for opioid use disorder that was developed a few years ago, and we are in the process right now of updating that.

Another thing that I'm very happy with on the policy level is that the federal government, in the past three-and-a-half years, has made behavioral health integration a much higher priority, and is devoting more resources to this generally. For the new contract that's just starting here in a few weeks, we're going to be having a federal interagency effort that we'll be involved with, coordinating to try to get policy issues addressed across federal agencies, and we're optimistic that that can make a difference, under AHRQ's leadership, of course.

Anybody else want to make a comment specifically on the substance use issues? And I didn't introduce, but we also have other members of the National Integration Academy Council available here, including Dr. Noah Nesin, who works in the substance use area in Maine. And Noah, would you care to make a comment on this topic?

Noah Nesin: Yeah. I saw that question pop up and started writing down ideas, and I filled the page, but I will be succinct, I promise, because I'm sure there are lots of thoughts about what could be done in this regard. But treating opioid use disorder, or any substance use disorder, really is a perfect... Integrated team-based care is a perfect solution to that, both to address the needs of the patient and the needs of the team members, because vicarious trauma and moral injury are so common in this work, that it takes a team effort to sustain it and to remain healthy.

That team, I think, requires funding models, payment models that allow for flexibility in who can serve what roles on that team, including roles like peer recovery coaches, community health workers, pharmacists, which we've found particularly vital to this work, especially as we address comorbidities like hepatitis C or HIV, and all of that is really important in the payment model.

A payment model that allows for maximum flexibility to meet the person with a substance use disorder where they are in that moment, and that includes the ability to have enough financial stability to be confident in having open-access scheduling so that we really have the opportunity to literally save people's lives, especially, the people who are at most risk of dying in the short term are the least likely to be able to keep appointments when we'd like to schedule them. And so, being able to be sustained in a way that allows us to be as flexible as possible in that regard. That care has to be fully trauma-informed by everybody involved in the delivery of that care. Everybody they meet in that setting has to be fully trauma-informed.

And then pharmacologically, I think it's really vital that we and the system recognizes that it's a rapidly evolving approach to care from just a few years ago, where we were using low- to modest-dose buprenorphine, for instance, in primary care settings, to now where we're using quite high-dose buprenorphine in primary care settings, where we had significant barriers in the past to every attempt that we can do to make it as low-barrier care as possible, because the people, again, at most risk of dying are most likely to suffer from the kind of barriers that we all experience every time we try to access any kind of healthcare in this country. And then we have to be able to apply all of that to telehealth and to rural settings, where these issues are no less a problem.

Garrett Moran: Very good. Thank you, Noah. That's an-

Noah Nesin: My pleasure.

Garrett Moran: ... excellent, excellent answer. I'm going to just sort of skip around here, because there's just a whole bunch of very good questions, but one of them was aimed at you, Sandy, Dr. Blount. You mentioned the exemplars, and can you just give a quick mention of who you had in mind?

Alexander Blount: Well, one was Cherokee Health Systems in Tennessee. Cherokee started having behavioral health and medical in the same building something like 60 years ago. Those folks have been at it, and they've been getting better right along, and one of our members of the NIAC is the CEO there. But there are many others. There are a number around in the Seattle area. There are a number that are less experienced but highly evolved in various places around the country. There are some in Texas. There are some in many states. And if somebody wanted to find somebody in their state, I'd be glad to try and hook them up.

Garrett Moran: And I have to mention too, I previously mentioned Dr. Jürgen Unützer at the University of Washington, who has been working in the collaborative care model, a type of integrated behavioral health model, for many decades, had published extensive literature showing effectiveness and cost-effectiveness of that approach. And they operate the AIMS Center, A-I-M-S Center, at the University of Washington that provides all kinds of detailed support for implementing that particular variety of integrated care. Danielle, you wanted to comment on something here too?

Danielle Durant: No, I'm good. I'm reading ahead to some of the other great questions in the chat. So you can continue.

Garrett Moran: Okay. All right. So here's a question from Jennifer Thomas, "How can we foster engagement with medical organizations, AMA, AAFP, AAP, so that integrated behavioral health is seen as the standard of care by medical providers themselves?" She says, "As a family member, primary care practice, working in integrated care, I still feel that IC seems like the exception rather than the rule, at least on the national level. Hoping to change that." And we hope to change that too, Jennifer.

I mentioned that in this new contract period that's just starting, we're going to have this federal interagency council. The other thing the Academy has been charged with doing is reaching out and building connections with all of these groups, and we've already started that process. We've had discussions with AMA, which has a group focused specifically on expanding integrated care, and we work all the time with AAFP. We've pretty much always had AAFP representatives on the NIAC, the Integration Academy Council. So we're all in on trying to make those connections and build those relationships. Sandy.

Alexander Blount: And sometimes the organizations are ahead of their members. The American Medical Association has a training program for members in integrated care, and has a STEPS Forward program of online training, and integrated behavioral health is one of the elements of that program.

Garrett Moran: Frank deGruy is another NIAC member. He's a professor at the University of Colorado. And Frank, you want to mention the work you've been doing with the research in primary care and also AAFP?

Frank deGruy: Thank you, Garrett. Let me mention something else instead in just the couple of minutes that goes a little bit more directly to the issue of the buy-in or the acceptance in the general primary care world. Primary care is under the gun right now. It's actually losing ground in this sort of commodified version of healthcare, where family physicians and primary care clinicians do what's left after the profit-takers have peeled away the parts of primary care that are profitable. It creates a problem.

But other than the American academies and the colleges, I want to single out the National Academy of Sciences, Engineering, and Medicine, NASEM, and NAM. Going back to when it was the IOM, there have been a series of extraordinary reports beginning in 1996 about primary care, how it should be formulated, how it should be rendered, and the effects of integrated care on the health of populations. The most recent of those reports is just a couple of years old now.

NASEM published a report on whole-person care, which basically advocated very eloquently for the formulation of primary care as fully integrated with behavioral healthcare. Those are inseparable and need to be clinically, administratively, and financially integrated, and raised some very high-level and interesting policy issues as to how that might come to pass, which are actually in the process of getting implemented in a somewhat desultory fashion, but somewhat surprisingly, pretty well. So I think there actually is progress on the primary care side of this. There needs to be a lot more.

Garrett Moran: Yes. That's some very good resources there. And I'll mention that Frank has been a member of some of those panels that have done this great work. It's been really, really good stuff. We're just about out of time. Are we going to go a couple minutes longer, Danielle?

Danielle Durant: I think so. Those that would like to stay on, please do so, but I think we'll take a couple more of our audience questions and go until about 15 after.

Noah Nesin: Sorry, people are asking for where they can contact for follow-up questions. So if somebody might put that in the chat, the people who have to leave might appreciate that.

Danielle Durant: Yup. I'll respond right now.

Garrett Moran: Okay. Great. So there's a couple of questions on the workforce issues, and a suggestion from some of the professional associations of the various counseling groups could be influential here. Is anybody working with them, Stacy? Is that something that you're involved in, or Sandy, working with these groups?

Alexander Blount: We'll start with Stacy. She's very involved with them.

Garrett Moran: Okay.

Stacy Ogbeide: Yeah. So I would say the one entity that has linked all of the guild-specific groups is the Collaborative Family Healthcare Association, CFHA. For those who aren't familiar with that group, I would say that's the main hub that is doing its best to reach out to AAMFT, the ACA, APA, all of those groups, to address... I think that's an incredible question, and needed. I absolutely agree, and you're right. When it gets guild-specific, it can get a little touchy with that. So thank you for that question. And it is on the radar for sure to at least figure out how we can work together, like Dr. George had mentioned in the chat. So thank you for that. I'll hand it over to Sandy.

Alexander Blount: No. Make space for the next question. You've gone silent on us, Garrett.

Garrett Moran: Yeah. My voice doesn't sound as good with the mic off, does it? But Aaron Archer is pointing out that, is this AMA, Aaron, has a great compendium of documents related to behavioral health integration resources. And if it is AMA... Yeah, AMA. And we are working with them. We made a point of making sure that their members all got invitations to this webinar, and we'll be working with them more closely in the months ahead. So thank you for reminding us of that. Danielle, did you see other questions that...

Danielle Durant: Someone made a comment that they had recently attended a CMS event related to rural healthcare, and the difficulty of billing for both medical and behavioral health on the same day was a critical topic that was raised. And apparently, CMS took that seriously and on board as an issue that they're planning to address. I know, Beth, you already kind of touched on that a little bit, but I thought talking about this rural health and behavioral health concept might be good for further discussion, if anybody wanted to comment.

Garrett Moran: Okay. Yeah. As I understand it, Beth, correct me, but CMS has already tried to make it clear that it's not a federal requirement. I'm a native of West Virginia and did a lot of work there, and it was an edit built into their Medicaid Management Information System that wasn't easily resolved. But getting rid of that is a challenge. We really are right at the end of our time, or maybe a little bit over. Does anybody else have a final thought or comment they'd like to make before we close out for the day?

Alexander Blount: I would just like to say that the example of the federal government making it clear that something is okay, and it's still not being implemented. In fact, people still insisting that it's not okay is an example of the stress between the sort of fear of doing something that might be risky or new that everybody has and the benefits of serving patients so much better. And it's so important to keep our eyes wherever we can on the patients and what we're going to do for them, and see if we can deal with the... makes us a little uncomfortable to do things differently.

Garrett Moran: Well said. Yeah. And it takes principled leadership to move these issues forward in any context. Any other thoughts? If not, I'd just like to thank everybody for your participation. This has been a very good discussion, and we will have a recording coming out in a couple of weeks. Thank you for your time. I hope the rest of your day goes well. Take care.

Danielle Durant: Thank you all so much.

Alexander Blount: Thank you.