HEALTHY MINDS POLICY INITIATIVE

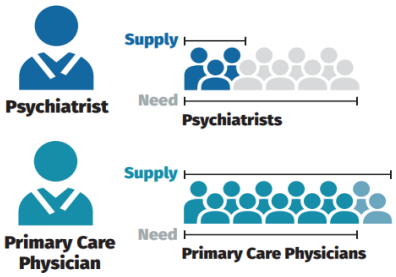
Integrating Behavioral Health and Primary Care in Oklahoma

The Urgency, the Landscape, and Next Steps

As noted in our recent report on the state of the behavioral health workforce, Oklahoma faces a serious behavioral health workforce shortage.[1] Integrating behavioral health care into primary care ("integrated care") is a promising opportunity to expand the behavioral health workforce to include primary care providers, of which we have a higher-than-average number in Oklahoma. Improving the ability to detect and treat mental health conditions in primary care settings ensures more individuals get the help they need when they need it, preventing future mental health crises that cost Oklahomans' lives and livelihoods. ***This document presents a comprehensive overview of integrated care: its necessity in Oklahoma, popular models around the country, the evidence supporting its success, and policy and system enhancement opportunities that could support its dissemination and adoption.***

Overview

Over 590,000 adults in Oklahoma, 20.4% of the population, are currently living with mental illness.[2] Despite this prevalence, 59% of adults with mental illness do not get the care necessary to manage their conditions.[3] This lack of treatment access has many consequences. The rising rate of suicide in the United States and the current 23-year lifespan disparity between individuals with serious mental illness and those without illustrate the most severe of these consequences.[4]



Need vs. Supply: Federal standards of practitioner availability per 100,000 residents show Oklahoma's primary care workforce surpasses estimated need, while the behavioral health workforce falls far short.

One possible avenue to increase access to behavioral health care and prevent these early deaths is through the integration of physical and behavioral health care.[5] Within integrated care, multi-disciplinary teams of primary care physicians, behavioral health professionals, care managers, and others work together to monitor and treat both behavioral and physical health needs in a cohesive, evidence-based way.

Through a months-long research process including reviews of relevant literature and key informant interviews, Healthy Minds identified the key features of integrated care models and their use in Oklahoma, ultimately recommending key methods of advancing integrated care in Oklahoma. Using a snowball methodology of sampling (in which we selected interviewees we knew had expertise in integrated care and then asked them for recommendations as to who else we should interview) we

[1] Healthy Minds Policy Initiative. (2020, December). *Healthy Minds launches workforce policy series.* https://www.healthymindspolicy.org/workforce/

[2] Mental Health America. (2021). Prevalence Data 2021. Mental Health America https://www.mhanational.org/issues/2021/mental-health-america-prevalence-data

[3] Mental Health America. (2021). Access to Care Data 2021. Mental Health America. https://www.mhanational.org/issues/2021/mental-health-america-access-care-data

[4] As a note, the problems with behavioral health access and the worsening outcomes summarized here have only been exacerbated by the COVID-19 pandemic. If anything, the estimates concerning inadequate access, rising mental health concerns, and the need for better and more accessible services throughout this paper are conservative.

[5] For the purposes of this paper, the term "behavioral health" encompasses both mental illness and substance use disorders.

interviewed twenty-two individuals connected to integrated care in Oklahoma. Key informants included primary care practitioners, members of organizations providing support for integrated care, clinical leaders and administrators, state agency representatives, and faculty at academic institutions.

Key Takeaways:

Integrated care is an avenue through which to begin to "move the needle" on improving outcomes for individuals with mental illness and substance use disorders. Integrated care models can address many of the barriers to care faced by Oklahomans today, such as lack of practitioner availability and difficulties finding a valid entry-point to care. Benefits include:

- Increasing the reach of mental health resources to more patients and expanding early identification and prevention services;
- Improving coordination between primary care providers and behavioral health specialists, which allows for better treatment planning and more cohesion of care; and
- Reducing overall health care costs for both behavioral and physical health concerns by treating conditions before they reach a crisis point, avoiding hospital admissions and readmissions, and reducing emergency room visits.

The Oklahoma landscape is ready for integrated care, and early progress can be celebrated.

- Oklahoma is well-positioned for integrated care and can utilize its higher-than-average number of primary care physicians to supplement the limited behavioral health workforce.
- There are several integrated care initiatives across Oklahoma, but many struggle with systemic problems – such as an insufficient workforce and referral network, challenges with financing, and a lack of behavioral health training for primary care providers – that prevent them from implementing full, evidence-based models of integrated care.

The following policy and system enhancement changes would simplify and support the use of integrated care:

- **Primary care training**: Primary care physicians need ongoing comprehensive, evidence-based training during residency and throughout their careers on how to detect and treat mental illness;
- **Sustainable funding for integrated care models**: Oklahoma should ensure that public and private insurance codes for integrated care models such as the Collaborative Care model and SBIRT (Screening, Brief Intervention, and Referral to Treatment) are active, readily available, and appropriately reimbursed;
- **Quality improvement**: Oklahoma should ensure integrated care practices are operating "true to the model" and achieving improved outcomes by performing quality-assurance fidelity assessments of clinics currently using integrated care, and provide support and technical assistance to clinics as needed;
- **Expand consultation models**: Grant funding available from the American Rescue Plan Act of 2021 should be pursued to create a statewide "child psychiatric access network," which would allow pediatricians and family practice doctors to consult in near real-time with child psychiatrists;
- **Rural telehealth support**: Oklahoma should use financial incentive programs to encourage primary care practices to open up a room with a laptop for patients to use for their telehealth visits, both for mental health care and physical health care;
- **Expand the behavioral health workforce**: While primary care physicians can treat a majority of mild to moderate mental health conditions, severe cases still require behavioral health specialists. Oklahoma should invest in more training programs for behavioral health specialists and add

additional psychiatry residencies, particularly in rural areas; and

- **Behavioral health professional training**: Oklahoma should incorporate appropriate integrated care training into educational programs for behavioral health professionals.

THE PROBLEM

Unmet Need

Many people in Oklahoma struggle with mental illness and substance use disorders.

- An estimated 590,000 adults, or 20.4% of the adult population in Oklahoma, are living with a diagnosable mental health condition.[6]
- As many as 207,000 Oklahomans experience at least one major depressive episode in a given year. This prevalence rate, at 7.0 episodes per 100,000, is higher than the United States overall, which see an average of 6.7 episodes per 100,000.[7]
- More than one in ten adults in Oklahoma, between 700,000 and 950,000 individuals, are living with a diagnosable substance use disorder.[8]

However, despite the prevalence of mental illness and substance use disorders many people do not get the behavioral health care they need. **Reports estimate that 59% of adults in Oklahoma with any mental illness do not get the care necessary to manage their condition.** [9] Approximately 61% of Oklahoma youth with depression in the past year did not receive treatment.[10] Nationally, the rate of unmet need is similarly high. In 2019, the National Survey on Drug Use and Health estimated that 80% of individuals with a substance use disorder, 57% of those with mental illness, and one-third of those living with serious mental illness did not receive treatment.[11]

Barriers to Treatment

Many obstacles – cost, stigma, lack of insurance, limited providers – can prevent an individual from receiving needed treatment.

[6] Mental Health America. (2021). Prevalence Data 2021. Mental Health America https://www.mhanational.org/issues/2021/mental-health-america-prevalence-data

[7] Healthy Minds Policy Initiative. (2019, July). *State of depression and suicide in Oklahoma.* https://www.healthymindspolicy.org/wp-content/uploads/2019/11/OK-and-Tulsa-Depression-Suicide-0601420194-final.pdf

[8] Oklahoma Department of Mental Health and Substance Abuse Services. (n.d.). *Mental Health and Substance Abuse Prevalence for Oklahoma.* http://www.odmhsas.org/eda/prevalence.htm

[9] Mental Health America. (2021). Access to Care Data 2021. Mental Health America. https://www.mhanational.org/issues/2021/mental-health-america-access-care-data

[10] Mental Health America. (2021). Youth Data 2021. Mental Health America. https://mhanational.org/issues/2021/mental-health-america-youth-data#five

[11] Substance Abuse and Mental Health Services Administration. (2020). *Behavioral Health Workforce Report*. https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf

Lack of or inadequate insurance coverage. As recently as 2018, Oklahoma had the second-highest rate of residents living without health insurance, with 548,000 uninsured citizens.[12] This will start to change with Medicaid expansion beginning July 2021, as more Oklahomans become eligible for Medicaid, but there will still be individuals living without insurance. This population is left to either pay out of pocket for services (something that's often prohibitively expensive) or manage their condition without treatment. Too often, these untreated problems end in involvement with the criminal justice system or costly emergency or inpatient treatment.

Due to a lack of parity in health insurance benefits for physical health and mental health, even many people who do have health insurance often struggle to access mental health care. "Parity" is the guarantee that behavioral health insurance benefits are treated comparably to medical or surgical benefits.[13] Despite becoming federal law in 2008, parity has not been fully implemented by all insurance companies.[14] In 2017, Oklahomans were **7 times** more likely to use out of network inpatient mental health services, and **9 times** more likely to use out of network outpatient facilities, when compared to medical/surgical use.[15] In 2020, Oklahoma passed Senate Bill 1718 in an effort to improve parity compliance on the state level.[16]

Stigma. Stigma involves negatively stereotyping or discriminating against individuals with behavioral health conditions because of their condition or disorder. Stigma can come from others, can be internalized and come from the self, or can be found in laws and policies on an institutional level. Stigma has been found through research to be a major barrier to care, with individuals not seeking out or participating in care because of the stigma (perceived or real) attached.[17]

Workforce shortages. Nationally, the average number of psychiatrists leaving the workforce each year is twice the number joining it.[18] Oklahoma has only 10.3 psychiatrists per 100,000 residents, when experts estimate that at least 30.3 are needed.[19] Oklahoma also has shortages in non-prescribing behavioral health professionals (BHPs), such as licensed psychologists and licensed clinical social workers (LCSWs).[20] This limited workforce adds an additional barrier to those seeking resources.

Clinical detection. When access to mental health professionals is limited, patients must rely on their primary care providers (PCPs). However, fewer than half (47%) of all cases of major depressive disorder (MDD) that present to primary care in a given year are detected, despite the fact that depression is a prevalent condition – one in eight people who visit primary care

[12] Casteel, C. (2019, September 11). Oklahoma uninsured rate still second-highest. Retrieved April 09, 2021, from https://www.oklahoman.com/article/5640909/oklahoma-uninsured-rate-still-second-highest

[13] Healthy Minds Policy Initiative. (2020). *Ensuring parity in Oklahoma: Leveling the playing field for mental health*. Retrieved January 11, 2021, from https://www.healthymindspolicy.org/parity/

[14] Center for Medicare & Medicaid Services. (n.d.). *The Mental Health Parity and Addiction Equity Act (MHPAEA).* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

[15] Ibid.

[16] Forman, C. (2020, May 20). New Oklahoma law will require mental health parity in health insurance. *The Oklahoman*. https://oklahoman.com/article/5662740/new-oklahoma-law-will-require-mental-health-parity-in-health-insurance

[17] Corrigan, P., Druss, B., & Perlick, D. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. Psychological Science in the Public Interest, 15(2), 37-70. Retrieved January 12, 2021, from http://www.jstor.org/stable/44151252

[18] Satiani, A., Niedermier, J., Satiani, B., & Svendsen, D. P. (2018). Projected workforce of psychiatrists in the United States: A population analysis. Psychiatric Services, 69(6), 710–713. https://doi.org/10.1176/appi.ps.201700344

[19] Healthy Minds Policy Initiative. (2020, December). *Oklahoma's behavioral health workforce: Greatest needs.* https://www.healthymindspolicy.org/wp-content/uploads/2020/12/HMPI-Workforce-Greatest-Needs_FINAL_12.11.20.pdf

[20] Ibid.

have MDD.[21] Even when MDD is detected, people infrequently receive appropriate care: Only 9% of people with MDD visiting primary care receive adequate treatment.[22]

Worsened Outcomes

For all of these reasons, mental health conditions often go undetected and untreated for too long, which leads to worsening of symptoms and unnecessary suffering. One study found that the median amount of time between the onset of depression symptoms and initiation of treatment was eight years.[23] Without proper detection and treatment, even mild mental health conditions can get worse over time. There is evidence that over a 10-year period, the conditions of people with mild mental illness can worsen to the point where they are nearly 3 times more likely to need psychiatric hospitalization than people who at the same baseline assessment point did not have any mental illness.[24] After 10 years, individuals who initially had mild mental illness were 2.4 times more likely to have a serious mental illness than those who initially had no mental illness.[25] Delaying detection and treatment can have serious consequences.

Nearly **half** of people who died by suicide had contact with primary care in the last month of their lives

The fact that the United States has one of the highest rates of suicide in the industrialized world adds additional concern.[26] During the 20-year period from 1999 through 2018, suicide rates increased 35%, from 10.5 suicides per 100,000 people in 1999 to 14.2 per 100,000 in 2018.[27] Suicide is preventable and can be avoided through careful treatment and support. The urgency of our need for improved detection and treatment of mental illnesses like depression is put into stark reality with this fact: Nearly half of people who died by suicide had contact with primary care in the last month of their lives.[28]

Aside from the risk of suicide and other deaths of despair[29], delays in treatment have additional negative consequences. Physical and mental health conditions are deeply connected, and untreated mental illness and substance abuse adversely affect outcomes for other co-occurring physical health conditions. For example, individuals with clinical depression are more than twice as likely as individuals without clinical depression to develop coronary artery disease or suffer a heart attack.[30] The reverse is also true – research

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[21] Pence, B. W., O'Donnell, J. K., & Gaynes, B. N. (2012). The depression treatment cascade in primary care: a public health perspective. *Current Psychiatry Reports*, *14*(4), 328–335. https://doi.org/10.1007/s11920-012-0274-y

[22] Pence et al. (2012). Cited above.

[23] Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 603–613. https://doi.org/10.1001/archpsyc.62.6.603

[24] Kessler, R. C., Merikangas, K. R., Berglund, P., Eaton, W. W., Koretz, D. S., & Walters, E. E. (2003). Mild disorders should not be eliminated from the DSM-V. *Archives of general psychiatry*, *60*(11), 1117–1122. https://doi.org/10.1001/archpsyc.60.11.1117

[25] Ibid.

[26] Tikkanen, R., Fields, K., Williams II, R. D., & Abrams, M. K. (2020, May 21). Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries: Commonwealth Fund. Retrieved December 30, 2020, from https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries

[27] *Suicide.* (2021, January). National Institute of Mental Health. Retrieved January 13, 2021, from https://www.nimh.nih.gov/health/statistics/suicide.shtml

[28] Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., Lynch, F., Owen-Smith, A., Hunkeler, E. M., Whiteside, U., Operskalski, B. H., Coffey, M. J., & Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870–877. https://doi.org/10.1007/s11606-014-2767-3

[29] "Deaths of despair" refers to deaths by suicide, opioid overdoses and alcohol-related illnesses. It is a phrase originally coined by Anne Case and Angus Deaton in their book *Deaths of despair and the future of capitalism.*

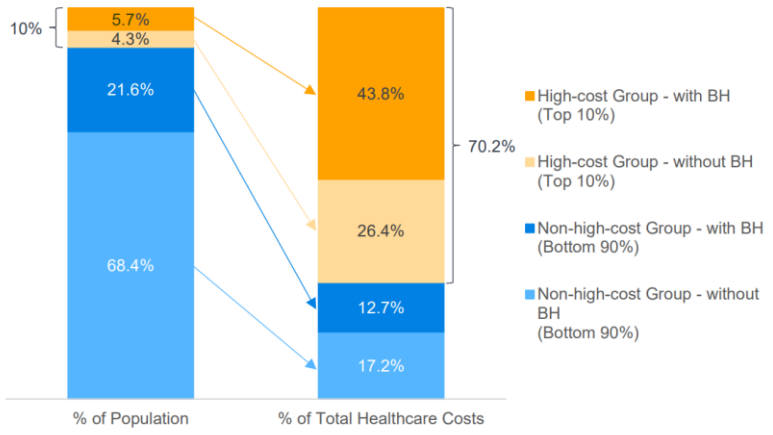
[30] American Psychological Association (n.d.). *Mind/body health: Heart disease.* http://www.apa.org/helpcenter/heart-disease.aspx

shows that approximately 50% of people with heart disease experience an episode of depression in their lifetimes, much higher than the 20% of the general population who experience an episode.[31] When coronary heart disease and mental illness co-occur, patients are at a higher risk for cardiovascular death.[32] In a study looking at co-occurring major depressive disorder (MDD) and diabetes, individuals with both conditions were 2.3 times more likely to die during a 3-year follow-up period than non-depressed patients with diabetes.[33] As another example, long-term use of methamphetamine can cause liver, kidney and lung damage.[34] Early detection and prevention of mental health conditions and substance use disorders in primary care can therefore also improve overall health.

Economic Costs

Because behavioral healthcare is relatively inexpensive compared to physical health care, addressing and treating mental health and substance use disorders provides an exciting opportunity to decrease healthcare costs overall and improve both behavioral and physical health outcomes. **According to one Milliman report, costs for treating physical health conditions like coronary heart disease are two to three times higher on average for those with co-occurring mental illness or substance use disorders than those without.**[35] Individuals with mental illness account for a disproportionate share of healthcare costs. Notably, those costs are primarily physical, with behavioral health related costs accounting for less than half of the overall costs of treatment.

FIGURE 4: DISTRIBUTION OF THE POPULATION AND TOTAL HEALTHCARE COSTS AMONG COST AND BEHAVIORAL HEALTH GROUPS, 2017



A subsequent Milliman study of 21 million individuals with employer-supplied commercial insurance in the United States dove deeper into this issue. In the study, the "High-cost Group" (the 10% of patients with the highest overall treatment costs), accounted for 70% of total healthcare costs. Individuals with behavioral health concerns made up a disproportionately high percentage of both the High-cost Group (57% of individuals in the High-cost Group had behavioral health concerns, compared to 5.7% in the total population) and of total healthcare costs (44%). Annual total

[31] Ibid.
[32] De Hert, M., Detraux, J., & Vancampfort, D. (2018). The intriguing relationship between coronary heart disease and mental disorders. *Dialogues in Clinical Neuroscience*, *20*(1), 31–40. https://doi.org/10.31887/DCNS.2018.20.1/mdehert
[33] Scherrer, J. F., Garfield, L. D., Chrusciel, T., Hauptman, P. J., Carney, R. M., Freedland, K. E., Owen, R., True, W. R., & Lustman, P. J. (2011). Increased risk of myocardial infarction in depressed patients with type 2 diabetes. *Diabetes care*, *34*(8), 1729–1734. https://doi.org/10.2337/dc11-0031
[34] Substance Abuse and Mental Health Services Administration. Learn About Methamphetamine. September 11, 2020. https://www.samhsa.gov/meth
[35] Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018, January). *Potential economic impact of integrated medical-behavioral healthcare* (Rep.). Retrieved November 18, 2020, from Milliman website: https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

healthcare costs in this High-cost Behavioral Subgroup averaged **$45,782**, but for half of these individuals, **less than $95** of that went toward behavioral health treatment.[36] These data suggest that better access to mental health treatment might reduce costs on the physical health care side.

Not only can providing better and more accessible treatment for mental illness save money in healthcare settings, but it can also positively impact the economy overall. For depression alone, the economic cost in the United States in 2010 was $210.5 billion, 50% of which was attributable to workplace costs.[37] Projected depression-related workforce productivity losses in 2012 were around $24 billion annually.[38] Studies have shown a significant linear relationship between depression symptom severity and productivity loss.[39] Meaning, for every 1-point increase on a common depression screening instrument (the Patient Health Questionnaire-9, or PHQ-9), individuals had an additional mean productivity loss of 1.65%.[40] As depression symptom severity worsens, productivity falls. This highlights the importance of effectively treating depression to reduce symptom severity. **Studies indicate that high-quality depression treatment reduces symptoms, improves work function, and is cost-effective.[41]** There is great economic potential in improving the treatment of depression and other mental illness.

A SOLUTION: INTEGRATED CARE

Core Tenets of Integrated Care

To address a multifaceted problem such as the lack of identification and treatment of mental illness, we will need a multifaceted solution. No one policy or program can solve this problem alone. It will require improvements on many fronts – widespread adoption of prevention programs, more accessible school- and community-based services, improved crisis system coordination, and a more robust behavioral health workforce are just a few of many interventions that will improve outcomes. Integrated care is one very important part of the solution.

There is no one standard, nationally recognized definition of integrated care. Rather, integrated care serves as an umbrella term for a number of models that combine behavioral and physical health care and work to improve whole health outcomes through the use of population-level strategies and coordinated, cohesive care carried out by a multidisciplinary team.

Models that successfully integrate behavioral and physical health care generally align with the following tenets.[42]

1. All patients are **universally screened** for behavioral health concerns in primary care, or for common medical conditions in behavioral health settings.

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[36] Davenport, S., Gray, T. J., & Melek, S. (2020, August 13). *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?* Milliman. https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

[37] Greenberg, P. E., Fournier, A. A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *The Journal of clinical psychiatry*, *76*(2), 155–162. https://doi.org/10.4088/JCP.14m09298

[38] Pence et al. (2012). Cited above.

[39] Beck, A., Crain, A. L., Solberg, L. I., Unützer, J., Glasgow, R. E., Maciosek, M. V., & Whitebird, R. (2011). Severity of depression and magnitude of productivity loss. *Annals of family medicine*, *9*(4), 305–311. https://doi.org/10.1370/afm.1260

[40] Ibid.

[41] Wang, P. S., Patrick, A., Avorn, J., Azocar, F., Ludman, E., McCulloch, J., Simon, G., & Kessler, R. (2006). The costs and benefits of enhanced depression care to employers. *Archives of general psychiatry*, *63*(12), 1345–1353. https://doi.org/10.1001/archpsyc.63.12.1345

[42] SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). *A quick start guide to behavioral health integration for safety-net primary care providers.* https://www.thenationalcouncil.org/integrated-health-coe/resources/

2. **Multi-disciplinary teams** work together to provide coordinated, comprehensive health care to individuals who have multiple health care needs.
3. A **population-based care** approach is taken, where care team members share a specified patient panel. Teams use a registry to track changes in patient symptoms so as to easily identify patients who are not improving. The team follows systematic evidence-based guidelines for interventions and conducts regular caseload consultations, so that no patient falls through the cracks.
4. Practices use **measurement-based care** to track symptom changes and adjust treatment. Patients are regularly assessed with evidence-based screening tools, such as the PHQ-9 for depression, and clinical care decisions are made based on the results of these tools and patient data collected over time.

This explanation of measurement-based care was shared with us by a psychiatrist in Oklahoma:
Measurement-based care ensures you're providing good medicine to your patients. Think about it like diabetes. With diabetes, you check your patient's A1c (blood sugar level) every 3 months. If your treatment – insulin, diet changes, medications, etc. – did not improve the A1c level in those three months, then you would adjust the treatment. The same is true for psychiatric treatment. At follow up visits, it is necessary to re-screen a patient with the same tool you used initially so that you have a standardized way to measure symptom changes. If there is no improvement in their symptoms, treatment adjustment is needed. This process continues until a patient reaches a point of stabilization.

Integrated care can be implemented in two settings:

Integrating physical health care into behavioral health care settings

People receiving ***behavioral health care*** at a specialty site for mental illness and/or substance use disorder are screened for physical health conditions (such as diabetes, hypertension, and high cholesterol). Those with physical health diagnoses receive team-based care that includes a primary care provider who works with the behavioral health care team.

Integrated care in behavioral health settings has been growing in popularity, particularly in community mental health centers. For those with serious mental illness (SMI) and co-occurring substance use disorders this second setting is often optimal for their treatment needs, as they more regularly need specialized psychiatric attention and care. With this type of integrated care, clinicians hope to address the drastic 23-year lifespan disparity between those in Oklahoma with SMI and those without.[43,44,45]

Since Oklahoma has a limited supply of psychiatrists, but a higher-than-average number of primary care providers, it has the capacity to expand access to behavioral health treatment broadly if it utilizes its primary care providers.[46] Integrated care in primary care can improve early detection and treatment for behavioral health conditions, ultimately improving outcomes. Integrated care improves access to treatment for many who struggle to find accessible specialty behavioral health services, do not realize

[43] Life expectancy estimates and causes of death are from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and based on data from state vital statistics and ODMHSAS clients between 2004 and 2013.
[44] Colton, C. W., & Manderscheid, R. W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing chronic disease*, *3*(2), A42.
[45] Aron, L., Bogle, M., Cohen, M., & Lipman, M. (2018). *Prevention, treatment, and recovery: Toward a 10-year plan for improving mental health and wellness in Tulsa.* Urban Institute. https://www.urban.org/research/publication/prevention-treatment-and-recovery-toward-10-year-plan-improving-mental-health-and-wellness-tulsa/view/full_report
[46] Healthy Minds Policy Initiative. (2020, December). *Oklahoma's behavioral health workforce: Greatest needs.* https://www.healthymindspolicy.org/wp-content/uploads/2020/12/HMPI-Workforce-Greatest-Needs_FINAL_12.11.20.pdf

they require support, or would prefer to be treated in a primary care setting. For this reason, the remainder of this paper will focus on evidence supporting integrated behavioral health care in primary care.

Levels of Integration

It is important to distinguish coordinated care or co-located care from integrated care. There are benefits to coordinated and co-located care, but they are unable to provide all the benefits of fully integrated care. The following table from the Center for Integrated Health Solutions provides a useful contrast between these different approaches to simultaneously addressing physical health and behavioral health conditions.[47]

Coordinated		**Co-Located**		**Integrated**	
Level 1: Minimal Collaboration	Level 2: Basic Collaboration at a Distance	Level 3: Basic Collaboration Onsite	Level 4: Close Collaboration Onsite with Some System Integration	Level 5: Close Collaboration Approaching an Integrated Practice	Level 6: Full Collaboration in Transformed/ Merged Integrated Practice
Clinical Delivery					
Separate treatment plans, screening and assessment models	Sharing of some treatment plans, based on provider relationships, screenings possibly shared through Health Information Exchange (HIE)	May use agreed upon screening for more effective in-house referral process and have shared evidence-based practices, but separate treatment plans	Specific, standard screenings, collaborative treatment planning, some evidence-based practices shared, focused on population needs	Consistent set of screenings guiding treatment interventions. Collaborative treatment planning and evidence-based practices.	Population-based medical and mental health screenings are standard practice with results available to all providers of care team with one treatment plan for all patients and evidence-based practices selected by team, used as standard
Patient Experience					
Physical and mental health needs are treated as separate. Patient must handle separate practice sites on own	Needs are treated separately, but records are shared. Patients are referred, but barriers to care can still exist	Health needs are treated separately, but at same location. Proximity improves referral process	Needs treated separately, but warm hand-offs occur to other providers, with improved referral and follow-up	Needs are treated as a team for patients with shared needs, separately for others with care responsive to patient needs	All needs are treated by a team, functioning together with patients experiencing a seamless health care response

[47] Center for Integrated Health Solutions. Six levels of collaboration/integration (core descriptions) https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Why Integrated Care Works

Integrating behavioral health care into primary care can improve health outcomes by:

- Increasing the reach of mental health resources to more patients receiving care in a variety of health care settings;[48]
- Expanding early identification and prevention services;
- Integrating cohesive treatments for mental and physical health conditions;
- Improving coordination between primary care providers and behavioral health specialists, allowing for more cohesive transition of care following inpatient stays and better-informed care through the combined expertise of PCPs and specialists;[49]
- Addressing health behaviors such as compliance with treatment recommendations, exercise and diet;[50] and
- Reducing overall health care costs for both behavioral and physical health concerns by avoiding hospital admissions and readmissions, reducing emergency room visits, and preventing the need for costly procedures.[51]

Ensuring that patients receive treatment for *both* physical and mental health conditions in primary care allows the physical and mental health treatments to inform and enhance each other. It prevents these conditions from worsening and often means they need less costly treatment in the future. For example, a laparoscopic surgeon working in an integrated physical health/behavioral health women's health clinic in Austin, Texas indicated that resolving behavioral health symptoms sometimes prevented the need for laparoscopic surgery and in other cases increased the likelihood of a positive surgical outcome.

This can lead to huge cost savings, increased efficiency in the healthcare system, and improved outcomes and quality of life for patients. t is difficult to be precise in estimating savings, so we have included a few potential savings estimates that have been proposed by consulting groups and policy researchers. The Washington State Institute for Public Policy estimates the net benefit of collaborative care (one particular model of integrated care) to be $10,322 per individual for depression and $12,545 per individual for anxiety.[52] A 2018 Milliman report estimated that across all insured populations (including commercial, Medicare and Medicaid), $38 to $68 billion could be saved through effective integration of medical and behavioral care.[53]

Integrated care is a 'one-stop-shop' for health care. It offers improved access to both physical and behavioral health care, and provides a way to address the barriers mentioned at the beginning of this brief:

Insurance Parity. With behavioral health care integrated into primary care settings, patients can be treated by their primary care provider. With the help of warm hand-offs and coordinated, team-based care, they'll have an easier time gaining access to services, and won't have to go out of network to find appropriate behavioral health care.

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[48] Integrated health care. (2013). American Psychological Association. Retrieved October 21, 2020, from https://www.apa.org/health/integrated-health-care

[49] Ibid.

[50] National Council for Behavioral Health. (2018, September 7). *The value of integrated behavioral health.* SAMHSA-HRSA Center for Integrated Health Solutions. *https://www.thenationalcouncil.org/wp-content/uploads/2018/10/The_Value_of_Integrated_Behavioral_Health_09.07.18.pdf?daf=375ateTbd56*

[51] Melek et al. (2018). Cited above.

[52] Washington State Institute for Public Policy. (2016, December). Benefit-Cost Results. http://www.wsipp.wa.gov/BenefitCost?topicId=8

[53] Melek et al. (2018). Cited above.

Stigma. Regularly screening every single patient while checking for vital signs and other preventive and lifestyle factors at their primary care site allows for the normalization of mental health evaluation and treatment. It helps to create a non-judgmental environment where patients can feel safe and encouraged to answer assessment questions and speak up about behavioral issues with which they are struggling. Incorporating screening and discussion as a regular part of a primary care practice helps to position primary care providers as champions of mental health care, reminding patients that treatment is available, that they are not alone in needing support, and that recovery is possible.

Workforce shortages. Oklahoma has a limited supply of psychiatrists, but it also has a higher-than-average number of primary care providers.[54] This makes integrated care an ideal option for improving access to behavioral health care in the state. With support from embedded behavioral health specialists, care managers and psychiatric consultation, primary care providers are capable of managing most behavioral health needs. While there will always be a need for specialty psychiatric care for the most serious behavioral health issues or most complex chronic conditions, increasing the number of primary care providers who treat behavioral health needs would expand Oklahoma's capacity to improve both behavioral and physical health outcomes significantly.

Clinical detection. Because people with mental health and substance use conditions often do not seek specialty mental health care on their own but are likely to visit primary care in a given year, there is a significant opportunity to identify patients and address unmet behavioral health needs through the integration of behavioral health care into primary care settings. Models which incorporate universal screening of all patients on a regular basis make it far less likely that a patient suffering from mental illness or a substance use disorder would get missed by clinical detection. Once patients in need of treatment are screened and detected, training PCPs to use evidence-based treatment-to-target protocols can go a long way toward improving patient outcomes.

Integrated Care Models

Integrated care is primarily an umbrella term, housing many different styles and models of use. Each model has its strengths and limitations, but all evidence-based or best-practice models should be considered when looking for a path forward. These models are not mutually exclusive – it is possible to combine various aspects of different models to create a system that works for a specific practice.

Collaborative Care Model

While integrated care at any level can help improve health outcomes, the **Collaborative Care Model (CoCM)** currently has the most research evidence behind it.

CoCM employs five core principles that make improved health outcomes possible.[55]

1. ***Patient-centered team care***: The collaborative care model employs three team members: a primary care provider, a care manager and a psychiatric consultant. The care manager and psychiatric consultant work together to support the overall clinical leadership of the primary care provider. The care manager can be a licensed behavioral health professional, in which case they

[54] Healthy Minds Policy Initiative. (2020, December). *Oklahoma's behavioral health workforce: Greatest needs.* https://www.healthymindspolicy.org/wp-content/uploads/2020/12/HMPI-Workforce-Greatest-Needs_FINAL_12.11.20.pdf

[55] Advancing Integrated Mental Health Solutions. (2017) Collaborative care core principles. University of Washington. http://aims.uw.edu/collaborative-care/principles-collaborative-care

can provide brief, evidence-based psychotherapy in addition to coordinating care.[56] **Teams collaborate regularly** using shared plans which incorporate patient goals. Patients receive physical and mental health care at one location, improving patient engagement and experience.

2. ***Population-based care***: Practices engaged in collaborative care address mental health and substance use on a population level, in part by **regularly screening every patient**, such that identifying mental illness or a substance use disorder is not left up to the patient to disclose or the provider to infer. Once identified, the care team uses a registry to track the clinical progress of the entire patient panel (or focal sub-groups with complex conditions), remind clients and staff of appointments and treatment milestones, and identify opportunities to improve care. The psychiatric consultant and care manager conduct regular caseload consultations which involve discussion of treatment-resistant cases, new patients, and the sharing of educational information and resources, which ultimately lead to general improvements in the delivery of care and better population-level outcomes.[57]
3. ***Measurement-based treatment to target***: A patient's treatment plan outlines personal goals and clinical outcomes that are measured with evidence-based tools (such as the PHQ-9 depression scale) to track progress and adjust treatment accordingly. Patients are kept on a shared, active caseload – where they are regularly reassessed and their treatment adjusted by the PCP, care manager and psychiatric consultant – until they obtain at least 50% symptom reduction, at which point they are moved back to the general primary care panel, where they are followed regularly by their PCP.[58]
4. ***Evidence-based care***: Patients are provided only research-backed treatments (e.g. problem-solving therapy, behavioral activation, cognitive behavioral therapy, evidence-based psychotropic medications) to improve treatment efficacy. Treatment may include medications, psychotherapy, or a combination of both. [59]
5. ***Accountable care***: While the collaborative care model can be delivered under various reimbursement mechanisms, it is more expensive to deliver than usual care (on the front end) and requires alternative payment approaches to be sustainable for most practices. Providers should be reimbursed for the higher-quality of care and better clinical outcomes delivered through collaborative care and not just the volume of care provided. Fortunately, Medicare has developed value-based payment codes for providers and many other payers have adopted them.

Studies have found that collaborative care leads to better mental health *and* physical health outcomes, and that it is cost-effective. In a large analysis of 79 randomized controlled trials of collaborative care, researchers found that patients being treated with collaborative care for depression or anxiety showed significantly greater improvement in outcomes in the short-term, medium-term, and long-term as opposed to those treated with usual care.[60] Results also showed improvement in secondary benefits including medication use, mental health quality of life, and patient satisfaction.[61]

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[56] Advancing Integrated Mental Health Solutions. (n.d.) Behavioral health care manager. University of Washington. https://aims.uw.edu/collaborative-care/team-structure/care-manager

[57] Advancing Integrated Mental Health Solutions. (2017). Collaborative care core principles. Cited above.

[58] Advancing Integrated Mental Health Solutions. (n.d.) Measurement-based treatment to target. University of Washington. https://aims.uw.edu/resource-library/measurement-based-treatment-target

[59] Medicare Learning Network. (2019, May). Behavioral health integration services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[60] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane database of systematic reviews*, *10*, CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

[61] Ibid.

Collaborative care also improves outcomes for physical conditions. In one study, for example, participants in collaborative care with depression and coexisting diabetes, coronary heart disease, or both saw positive improvements in their HbA1c levels (an indicator for diabetic management), cholesterol levels, blood pressure and depression scores over the course of a year. They also reported better quality of life and greater satisfaction with care for all of their conditions.[62]

A meta-analysis of 22 studies evaluating the cost-effectiveness of collaborative care indicated that collaborative care programs were at the very least cost-neutral, with most studies showing actual savings.[63] Typical cost savings estimates for patients receiving collaborative care range from 5% to 10% of total healthcare costs over a period of two to four years.[64] One study of collaborative care found that patients receiving collaborative care as opposed to usual care were 54% less likely to go to the emergency department and 49% less likely to utilize inpatient psychiatric care.[65] Both emergency care and inpatient psychiatric care are high cost services, so a significant reduction in the use of both indicates potentially significant cost savings.

Action in Oklahoma:
We have found minimal usage of collaborative care in Oklahoma, despite the collaborative care codes being available for patients insured with Medicare and Blue Cross Blue Shield. Oklahoma State University's Department of Psychiatry is currently developing pilot collaborative care programs in Tulsa and Tahlequah that will focus on training family medicine residents, psychiatry residents and doctoral candidates in psychology to work together within the collaborative care model. While there are still many details to be finalized, this is a promising effort both because of its financial viability and its focus on educating students, particularly family medicine residents. A recurring theme from key informant interviews with primary care physicians was that they were not adequately trained in residency to manage mental health or substance abuse concerns, so they feel hesitant to treat patients themselves, as opposed to referring out. The primary care physicians who were confident in managing psychiatric medications often attributed their comfort to a good mentor or a focus on mental health during residency.

Primary Care Behavioral Health (PCBH) Model

The PCBH model embeds Behavioral Health Consultants (BHCs) into the primary care setting. BHCs are specially-trained mental health providers such as clinical psychologists, clinical social workers, and licensed counselors, and they go far beyond co-located care by **coordinating with the primary care provider** on all aspects of behavioral health care for the patient. This starts with a same-day warm hand-off from the PCP to the BHC when a patient has behavioral health needs.[66] The BHC provides brief (i.e. 15-30 min), evidence-based screenings, assessments and interventions, with follow up as needed. BHCs provide educational information and resources to their patients and to their fellow team members in an effort to "improve the team's biopsychosocial assessment and intervention skills and processes."[67]

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[62] Katon, W. J., Lin, E. H., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., Peterson, D., Rutter, C. M., McGregor, M., & McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *The New England journal of medicine*, *363*(27), 2611–2620. https://doi.org/10.1056/NEJMoa1003955

[63] Jacob, V., Chattopadhyay, S. K., Sipe, T. A., Thota, A. B., Byard, G. J., Chapman, D. P., & Community Preventive Services Task Force (2012). Economics of collaborative care for management of depressive disorders: a community guide systematic review. *American journal of preventive medicine*, *42*(5), 539–549. https://doi.org/10.1016/j.amepre.2012.01.011

[64] Melek et al. (2018). Cited above.

[65] Jacob et al. (2012). Cited above.

[66] Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018). The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition. *Journal of clinical psychology in medical settings*, *25*(2), 109–126. https://doi.org/10.1007/s10880-017-9531-x

[67] Ibid.

Behavioral Health Consultants are:

Generalists[68]	The BHC engages with patients of all ages and various behavioral and physical conditions. This includes mental illness and substance use disorders, chronic disease (such as diabetes), preventive care needs (tobacco cessation, healthy eating), social and sub-diagnostic problems (child behavior problems, domestic violence), and medically unexplained symptoms (chronic fatigue or headaches).
Accessible	The BHC aims to see all patients on the same day that the PCP engages them in a "warm hand-off."[69] BHCs are accessible to PCPs for curbside consultations and to provide educational resources as needed.
Team-based	The BHC shares clinical space and resources with the rest of the primary care team. When the PCP refers a patient to the BHC, the two work together to create a treatment plan, follow up with the patient, and adjust treatment.
High Volume	The BHC conducts short (i.e. 15-20 min) evidence-based screenings, assessments and interventions with patients in order to see a high volume of patients each day.
Educators	BHCs provide educational information and resources to patients and to their fellow team members, helping to make the team more skilled, comfortable, and efficient in managing biopsychosocial issues.[70]
Routine	The BHC is viewed by patients and fellow team members as a routine and integral part of the primary care team.

The PCBH model is unique in its focus on addressing the behavioral and psychological components of physical health problems, such as stress, emotional reactions, and dysfunctional lifestyle behaviors.[71] For example, a patient with diabetes struggling to change their diet can work with a BHC to create a diet plan and identify activities or behaviors to help them adhere to it. In this way, BHCs can more directly help to improve outcomes for physical health problems.[72]

The PCBH model has been implemented in the U.S. Veterans Health Administration, the U.S. Department of Defense, Cherokee Health Systems, and various other settings including family medicine residency programs, university health centers, and homeless clinics.[73]

A 2018 article published by Hunter and colleagues reviewed 18 studies of the PCBH model and its patient outcomes. These studies found that from pre- to post-treatment, patients showed improvements in anxiety and depressive symptoms, PTSD symptoms, sleep symptoms, tobacco use, and weight.[74] Patients in every study reviewed also improved on Global Behavioral Health which includes every day functioning in work, school, completing household chores, and interpersonal relationships.[75] Both patients and providers reported high levels of satisfaction with PCBH model services. Patients stated that they would seek this type of care again in the future and would recommend it to others.[76]

[68] Ibid.
[69] In a "warm hand-off," the PCP provides a brief patient history, explains the behavioral health need, and then introduces the patient to the BHC. Conducting a warm hand-off and allowing the BHC to see the patient on the same day allow for improved patient receptivity and reduces the problem of "no-shows."
[70] Reiter et al. (2018). Cited above.
[71] Serrano, N. & Robinson, J. (n.d.). *What is the Primary Care Behavioral Health Consultation model?* Collaborative Family Healthcare Association. https://www.cfha.net/page/PCBHFAQDefinition
[72] Ibid.
[73] Ibid.
[74] Hunter, C. L., Funderburk, J. S., Polaha, J., Bauman, D., Goodie, J. L., & Hunter, C. M. (2018). Primary Care Behavioral Health (PCBH) model research: Current state of the science and a call to action. *Journal of clinical psychology in medical settings*, *25*(2), 127–156. https://doi.org/10.1007/s10880-017-9512-0
[75] Ibid.
[76] Ibid.

However, it is important to note that while the PCBH model has been implemented in many settings, the same review discussed above also concluded that "scientifically robust research" on the model was, at that time, lacking, indicating the need for more research on patient and implementation outcomes.[77]

Action in Oklahoma:

The Anne and Henry Zarrow School of Social Work, Center for Social Work and Healthcare at the University of Oklahoma in partnership with OU Health Physicians has been a leader in promulgating the PCBH model. After a successful pilot program funded by the University Hospital Authority and Trust, funds were used to support behavioral health consultant's first years' salary in OU Health primary care clinics for startup positions with the goal of financial sustainability. From there, and with the help of value-based payment initiatives such as Comprehensive Primary Care Plus (CPC+)[78], OU Health now has PCBH behavioral health integration in all primary care clinics and has expanded into women's health. The School has been able to offer technical assistance and support with implementation to other health systems in Oklahoma as well. OU Health plans to implement PCBH in pediatric clinics in the next year and further their behavioral health integration efforts.

INTEGRIS Health, a health system with hospitals, specialty clinics and family care practices located across Oklahoma, is also implementing the PCBH model. Fifteen of its family care practices are fully integrated with onsite behavioral health consultants embedded using the PCBH model. INTEGRIS' PCBH initiative started through the CPC+ program. They continue to use CPC+ funding, while also working to utilize the appropriate CPT codes to maximize reimbursement and ensure sustainability. INTEGRIS' continues to expand its program, with the goal of full integration in all primary care clinical settings.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based clinical pathway that is used to identify, reduce and prevent problematic use, abuse and dependence of alcohol and other substances.[79] SBIRT involves embedding a behavioral health professional into the primary care team. This option, as with other models, starts with **universal screening** of all patients regardless of an identified disorder using an evidence-based screening instrument, such as the Alcohol Use Disorders Identification Test, or AUDIT. This allows health care professionals "to address the spectrum of such behavioral health problems even when the patient is not actively seeking an intervention or treatment for his or her problems."[80] If a patient screens positive, either the primary care provider or the behavioral health professional conducts a brief intervention, which uses motivational interview strategies to increase the patient's awareness regarding their substance use and motivate them toward behavioral change. Brief intervention usually includes 1-5 sessions lasting anywhere from 5 minutes to an hour. If a patient is identified as needing more extensive treatment, the primary care team refers the patient to an outside specialty behavioral health care facility with which they have a relationship or agreement, so that they can share notes, engage in collaborative decision-making and continue tracking the patient's progress.[81]

[77] Ibid.

[78] Comprehensive Primary Care Plus (CPC+) is a "national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation." For more information about CPC+, visit https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus.

[79] Oklahoma Department of Mental Health and Substance Abuse. (n.d.) *Prevention in practice*. https://oklahoma.gov/odmhsas/prevention/prevention-initiatives/prevention-in-practice.html

[80] Substance Abuse and Mental Health Services Administration. (2011). *Screening, brief intervention and referral to treatment (SBIRT) in behavioral healthcare.* https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf

[81] Oklahoma Department of Mental Health and Substance Abuse. (n.d.). Cited above.

SBIRT's principles can be extended beyond alcohol and substance use to include screening, brief intervention and referral to treatment for mental health problems as well.[82] In this way, the model is well suited to address co-occurring mental illness and substance use disorders. SBIRT also has a strong preventive focus, employing motivational interviewing and brief intervention even with patients whose screenings are not yet at diagnostic levels of substance use or mental illness.

In 2013, the U.S. Preventive Services Task Force (USPSTF) reviewed current evidence on SBIRT in primary care to reduce alcohol misuse. Brief multi-contact behavioral counseling, in which each contact is 6 to 15 minutes, was found to have the best evidence of effectiveness, indicating that providers should engage their at-risk patients in multiple, short non-judgmental discussions about their current behaviors and recommended usage. [83] In both the 2013 Recommendation Statement and in an updated Statement released in 2018, they found that for adults aged 18 years or older, screening and brief behavioral counseling intervention reduces heavy drinking episodes, reduces weekly alcohol consumption rates and increases adherence to recommended drinking limits.[84]

For tobacco cessation, studies of the SBIRT technique in emergency departments suggest that "even low-intensity SBIRT may prompt quit attempts, decreased cigarette use, and quitting, if offered routinely to ED smokers."[85] SBIRT usage in emergency departments was "strongly and consistently" associated

with increased satisfaction with care.[86] This finding invites practitioners to continue discussing substance use and cessation counseling with their patients without fear that patients will seek care elsewhere. Further research into SBIRT use in primary care for tobacco use, other substance use and mental illness is necessary. There is minimal evidence surrounding the efficacy of SBIRT use in intervening with substances other than alcohol or with mental health concerns such as depression and anxiety. However, the similarities to other successful models in core concepts – universal screening, regular follow up and systematic management – bode well for its efficacy.

[82] Substance Abuse and Mental Health Services Administration. (2011). Cited above.
[83] Moyer, V. A., & Preventive Services Task Force (2013). Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. preventive services task force recommendation statement. *Annals of internal medicine*, *159*(3), 210–218. https://doi.org/10.7326/0003-4819-159-3-201308060-00652
[84] US Preventive Services Task Force, Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., Doubeni, C. A., Epling, J. W., Jr, Kemper, A. R., Kubik, M., Landefeld, C. S., Mangione, C. M., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2018). Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*, *320*(18), 1899–1909. https://doi.org/10.1001/jama.2018.16789
[85] MDQuit.org. (n.d.) *Screening, brief intervention, and referral to treatment (SBIRT)*. https://mdquit.org/cessation-programs/screening-brief-intervention-and-referral-treatment-sbirt
[86] Bernstein, S. L., Boudreaux, E. D., & American College of Emergency Physicians Smoking Cessation Task Force (2010). Emergency department-based tobacco interventions improve patient satisfaction. *The Journal of emergency medicine*, *38*(4), e35–e40. https://doi.org/10.1016/j.jemermed.2008.03.034
[87] Oklahoma Department of Mental Health and Substance Abuse. (n.d.) *Evidence-based services making a difference in Oklahoma.* https://oklahoma.gov/odmhsas/about/agency-overview/evidence-based-services-making-a-difference-in-oklahoma.html

Action in Oklahoma:
Of all the models, we have found that SBIRT is most widely used in Oklahoma. This is a result of the SBIRT-OK Project, developed by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and the University of Oklahoma Health Science Center's Oklahoma Primary Healthcare Improvement Cooperative (OPHIC). The SBIRT-OK Project uses an expanded model of SBIRT to screen for and manage alcohol and drug use, depression, anxiety, and suicidality. When a practice signs up for the program, OPHIC provides practice facilitation, technical assistance, information on best practices, and feedback on performance to help them implement universal behavioral health screening, interventions, and referrals for behavioral health treatment. ODMH provides various support, including tablet-based survey instruments, information on SBIRT billing codes and referral assistance. The ODMH website has online tools and resources including quick guides for appropriate screening, clinical guidelines for evidence-based intervention protocols and online trainings. The SBIRT-OK initiative has also collaborated with four health systems in the state (Integris Health, St. Anthony's, OU Medical, and Community Health Centers Incorporated) to support them in developing integrated care programs.[87]

The Oklahoma Primary Care Association (OKPCA) provides support to its member federally qualified health centers (FQHCs) in integrating behavioral health care into their primary care settings. This often occurs through the use of a hybrid model of SBIRT combined with many of the techniques and elements of other models of integrated care, such as PCBH. The OKPCA provides guidance on the integration of behavioral health consultants with the primary care team. They assist practices with practice facilitation, training and technical assistance including access to an integrated screening software.

VitalSign[6]/SMART-D

VitalSign[6] got its name because its creators, Dr. Madukhar Trivedi and colleagues, conceptualized depression as the sixth vital sign and believed that, along with blood pressure and other vital signs, screening for depression in primary care should be completed regularly.[88] VitalSign[6] (VS6) and its accompanying program, SMART-D (Screening, Measurement and Assessment of Response to Treatment of Depression) focus on helping primary care providers manage behavioral health concerns directly, particularly for patients who have mood disorders, anxiety disorders and suicidality. Unlike the collaborative care and primary care behavioral health models, VitalSign[6] does not rely on psychiatric consultants or embedded behavioral health consultants.

VS6/SMART-D is a web-based software program that administers mental health assessments (i.e. PHQ-9) to patients.[89] If a patient screens positive for depression, for example, VS6 provides guidance to the PCP on diagnostic criteria and helps them to determine if a diagnosis of depression is indicated. It then draws on research-based treatment algorithms to provide the PCP with detailed, automated guidance in identifying treatment options appropriate for that patient. This includes medication, psychosocial treatment and lifestyle changes as well as guidance on how to discuss these options with the patient. At follow up visits, PCPs utilize measurement-based care to determine next steps. Patients retake the appropriate screening assessment and VS6/SMART-D provides the PCP with longitudinal data on symptom changes and side effects to help inform treatment decisions and adjustments made by the PCP.[90]

[88] Trivedi, M. H., Jha, M. K., Kahalnik, F., Pipes, R., Levinson, S., Lawson, T., Rush, A. J., Trombello, J. M., Grannemann, B., Tovian, C., Kinney, R., Clark, E. W., & Greer, T. L. (2019). VitalSign[6]: A Primary Care First (PCP-First) Model for Universal Screening and Measurement-Based Care for Depression. *Pharmaceuticals (Basel, Switzerland)*, *12*(2), 71. https://doi.org/10.3390/ph12020071
[89] UT Southwestern Medical Center. (n.d.). *VitalSign[6]*. https://www.utsouthwestern.edu/education/medical-school/departments/psychiatry/research/center/vital-sign6/
[90] Trivedi et al. (2019). Cited above.

VS6 and SMART-D's software is interoperable with major electronic medical record (EMR) programs used by most primary care providers. It provides templates for documentation that are compatible with common EMR software in an effort to increase efficiency. Implementing VS6/SMART-D would be ideal for a practice that has at least some technology resources on hand and limited behavioral health clinical staff resources.

VitalSign[6] is still a fairly new program, and has not been as widely implemented as the CoCM, PCBH, and SBIRT models, so there is limited data on its effectiveness. One study indicated that, despite high attrition rates, remission rates increased as the number of follow-up visits increased, with a 42% remission rate in those patients with three or more follow-up visits – high compared to the 6% remission rate of usual care.[91,92] Another study highlighted the positive benefits for providers. The VS6 program "increased knowledge, changed attitudes, and enhanced providers' depression screening and treatment skills over time."[93]

Additional Insights from Analysis of Local Initiatives

As shown in the examples throughout the previous section, it is clear that integrated care efforts are happening in some of Oklahoma's primary care practices. SBIRT is the predominant model, as it is supported by multiple large entities including ODMH and OPHIC. However, there are practices and organizations experimenting with and advocating for other models, as well as other styles of integration that do not fall neatly within a model. Through key informant interviews, we have learned that:

- Some practices are experimenting in creative ways with adaptations of the models of integrated care;
- Universal screening is the bedrock of current integrated care use in Oklahoma;
- Measurement-based care is not as widely used to manage behavioral health as it is to manage physical health conditions; and
- Many practices are encountering obstacles in their attempts to utilize integrated care, including lack of provider training and buy-in, workforce limitations, minimal referral resources, challenges with technology, and financing concerns.

With respect to the creative experimentation with and use of integrated care models and approaches: Saint Francis Health System in Tulsa alone has three different integrated care initiatives ongoing, none of which fall directly under one model.

1. **Electronic curbside consultation.** Psychiatrists at Laureate Psychiatric Clinic and Hospital (a part of Saint Francis Health System) are able to provide informal "curbside consultation" on a patient through the electronic medical record when requested by a primary care provider within Warren Clinic, which encompasses the primary and specialty care providers in the Saint Francis Health System. While this is not considered fully integrated care, it does provide PCPs with psychiatric

[91] Jha, M. K., Grannemann, B. D., Trombello, J. M., Clark, E. W., Eidelman, S. L., Lawson, T., Greer, T. L., Rush, A. J., & Trivedi, M. H. (2019). A Structured Approach to Detecting and Treating Depression in Primary Care: VitalSign6 Project. *Annals of family medicine*, *17*(4), 326–335. https://doi.org/10.1370/afm.2418

[92] Pence et al. (2012). Cited above.

[93] Kahalnik, F., Sanchez, K., Faria, A., Grannemann, B., Jha, M., Tovian, C., Clark, E. W., Levinson, S., Pipes, R., Pederson, M., & Trivedi, M. H. (2019). Improving the identification and treatment of depression in low-income primary care clinics: a qualitative study of providers in the VitalSign6 program. *International journal for quality in health care : journal of the International Society for Quality in Health Care*, *31*(1), 57–63. https://doi.org/10.1093/intqhc/mzy128

specialty advice when needed, in order to better equip them to feel comfortable managing mild to moderate psychiatric needs in a primary care setting.

2. **Embedded behaviorist.** Two Warren Clinic practices utilize this initiative, in which an LCSW is employed within the primary care practice and receives warm hand-off referrals from the PCPs at that site. This program is similar to that of the PCBH model.
3. **Behavioral health integration virtual clinic ("Beehive" clinic).** This program focuses on depression, and is most similar to the collaborative care model. The program developed a standardized way to screen for depression, a treatment algorithm for PCPs to follow, and a clear referral process. PCPs follow the algorithm in working patients through up to 3 trials of a psychiatric treatment plan. Throughout the 3 trials, the patient and PCP have the support of a pharmacist care manager and the PCP has access to a psychiatric consultant as needed. If patients' screening scores are still above a certain threshold after the 3 trials, they are then referred to the psychiatric consultant for traditional psychiatric treatment. Two-thirds of patients have been found to respond to the algorithm within the primary care setting, which saves the psychiatrists' time and attention for the more complex, serious cases.

Another program in Oklahoma that does not promote a specific model is ROK-Net, the Rural Oklahoma Network. ROK-Net is a program created by the Oklahoma State University Center for Health Systems Innovation and Center for Health Sciences. ROK-Net is a practice-based research network and provides resources and support for rural primary care practices struggling with common problems. While ROK-Net doesn't specifically promote or implement any particular integrated care model, they have supported practices in improving their response to behavioral health needs. They do this work on an individual level – first understanding the specific needs and obstacles of the clinic, and then working with the clinic to adjust workflows and create solutions.

While the individual models are the forms of integrated care that have the most research backing their success and outcomes, our analysis of the models found that they are not incompatible and could even supplement each other in promising ways. For example, the combination of the specific expertise and accessibility of the behavioral health consultant in the PCBH model would complement the knowledge-base and support of the psychiatric consultant within the collaborative care model. While fidelity to a model is helpful in ensuring positive outcomes, successful integration might also be achieved in a hybrid model.

When a hybrid is taken, it is important to identify the key elements of integrated care that are either empirically shown to be effective or that are widely thought by experts in the field to be fundamental to integrated care service delivery. These include universal screening, collaborative multi-disciplinary teams, population-based care, and measurement-based care. For example, measurement-based care (MBC) has been empirically proven to produce good outcomes. One large study reviewing fifty-one relevant articles on MBC showed that "virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes."[94] Fidelity to these aspects of the models will help to ensure success.

In Oklahoma, universal screening for behavioral health conditions appears to be the bedrock of integrated

[94] Fortney, J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. *Psychiatric services (Washington, D.C.)*, *68*(2), 179–188. https://doi.org/10.1176/appi.ps.201500439

care. Almost all implementations, regardless of model, implement universal screening (or at least widespread screening). While some clinics do still struggle to find time to screen all patients, the vast majority of programs and practices we spoke with are implementing at least this aspect of integrated care and clearly see its importance.

We conducted a survey of primary care practices across the state in partnership with ODMH and OPHIC. While the sample size was small and self-selected, we did gain some important insight into key components of integrated care programs in Oklahoma and challenges that some Oklahoma primary care practices are facing. The widespread use of universal screening was one key theme.

Percent of responding Oklahoma practices that screen all patients at least annually for:				
Adolescents[95]			**Adults**	
Depression	83.8%		Depression	80.0%
Anxiety	60.6%		Anxiety	55.6%
Suicidality	68.8%		Suicidality	60.0%
Alcohol	71.9%		Alcohol	77.1%
Substance Use	71.9%		Substance Use	75.8%

It is important to note that screening universally does not equate with integrated care. Even many clinics that do not use any model of integrated care are doing universal screenings. One pediatrician we spoke to explained that though her clinic did not utilize any sort of integrated care system, they screen every patient 12 years old and older for depression and substance use. This is in part because the American Academy of Pediatrics added these screenings to their recommended periodicity schedule.[96] The challenge for many practices is what to do with the screening results.

Often the screening is, as in the case just mentioned, for a limited number of conditions, like depression and substance use. For example, many in the Comprehensive Primary Care (CPC/CPC+) program are required to identify one mental health or substance use condition to screen for and treat and that often results in a singular focus on depression in applying universal screening.

We found that many of the initiatives and practices we spoke with struggle to adhere fully to the other tenets and therefore are not using the full, evidence-based models. There is limited data collection or population tracking happening. Many we spoke to were not tracking outcomes as they went and were unable to tell us if they had seen overall positive outcomes from their implementations. Beyond individual clinical sites not having robust data, several individuals cited the lack of statewide data available and felt that this contributed to the limited uptake of integrated care and the fragmented behavioral health system.

[95] Screening for tobacco, alcohol or drug use is recommended for children aged 11 years and older, and screening for depression is recommended for children aged 12 years and older. To learn more, visit https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx

[96] American Academy of Pediatrics. (2021, March). *Periodicity schedule*. Retrieved June 6, 2021 from https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx

Similarly, there was discussion and awareness of measurement-based care (MBC) and the evidence behind it, but some said they hadn't been able to figure out how to implement it. **Measurement-based care has been shown to improve outcomes and PCPs use it regularly when tracking A1cs for diabetes and blood pressure for hypertension, but don't seem to have integrated MBC using behavioral health screenings into their workflows.**

Opportunity for Improvement:
Oklahoma should ensure integrated care practices are operating "true to the model" and achieving improved outcomes by performing quality-assurance fidelity assessments of clinics currently using integrated care. ODMH could utilize a local partner organization, such as OPHIC or ROK-Net, for example, to perform fidelity assessments. These assessments would be tailored to a particular model and would assess the extent to which the crucial evidence-based elements (universal screening, care coordination, measurement-based care, etc.) are in place and that the clinic is indeed achieving improved outcomes. The organization could then provide technical assistance, training and resources to assist clinics to meet requirements and appropriately follow evidence-based practices.

All of this is not for lack of trying – many have attempted to put the pieces in place for integrated care, but have run up against numerous obstacles due to broad-scale limitations of the healthcare system within Oklahoma. The following section outlines the most common obstacles we found in our interviews and research, followed by our recommendations concerning how to support more widespread dissemination and adoption of effective, evidence-based integrated care practices.

Obstacles Along the Way

Lack of primary care provider training and buy-in. A recurrent theme in our conversations with PCPs was the level of training they received in residency in managing behavioral health conditions (adjusting medications, counseling patients, etc.). Residency training is often where providers gain the skills and confidence to manage behavioral health in primary care settings. Those who did not feel comfortable managing behavioral health concerns themselves explained that they weren't trained to deal with behavioral health and that it isn't a major part of primary care residency training. One PCP told us that "unless you take a special interest in [behavioral health], you will refer out." On the other hand, those who did feel confident and comfortable managing behavioral health concerns cited exceptional psychiatric specialty educators in their residency programs.

Lack of appropriate training also contributes to a deficit of PCP buy-in. Providers are not necessarily resistant to incorporating mental health care – they recognize the overwhelming need for and benefit of this type of care – but they do have concerns and hesitations about it being disruptive to their workflow. Implementing integrated care does require clinical staff across the board to adjust their workflow, and provider buy-in, awareness of the value of the implementation, and willingness to adjust their current practices are critical to a successful implementation. It is important to incorporate an element of mental health education for the clinicians who will be changing their workflow, including nurses and medical assistants, so that they see mental health care as a medical need that is worth their time. Several individuals reported that once primary care sites had implemented an integrated care program and made the necessary changes to adjust their workflow, they were extremely pleased with the results. "Now that people are familiar with [integrated care], they don't know what they did without it."

Patient buy-in can also significantly affect an implementation. Some clinics, especially with geriatric and rural populations, report difficulty getting patients to consent to the screenings. Many refuse outright,

while others prefer paper screenings to electronic ones (a process which takes longer for the clinical staff to accommodate). With continued use of screenings in primary care, we feel that this issue will dwindle as it becomes normalized. When mental health screenings become as standard as blood pressure screenings, there will likely be less push back from patients.

Providers also report that some patients are hesitant to attempt psychotherapy, and that for those patients, the brief intervention style of counseling done by a PCP in a primary care setting is a helpful tool and a successful avenue. One PCP explained that despite patients being resistant to psychotherapy, they are grateful when she asks about their mental health or substance use and are willing to talk with her about their challenges and the changes they are trying to make. For these patients, integrated care is an ideal model for improved outcomes.

Opportunities for Improvement: Much of the hesitancy of PCPs to address and treat mental illness could be decreased with comprehensive, evidence-based training in residency. This was cited by PCPs as the best opportunity to help PCPs become more comfortable and capable managing behavioral health. Incorporating rotations in an integrated care setting and didactics on evidence-based treatment algorithms for mental health could go a long way in preparing the next generation of primary care providers to tackle the growing need for mental health support. One example of this can be found in INTEGRIS' Great Plains Family Medicine Residency program. Residents receive education on the importance of behavioral health integration, as provided by one of the clinical supervisors with a doctorate in behavioral sciences.

Continuing medical education (CME) opportunities for licensed providers are also necessary. OPHIC and ODMH are ahead of the curve in this way – we learned about several continuing medical education trainings on integrated care and treating behavioral health in primary care that were conducted through these entities. Unfortunately, many PCPs had not heard about these opportunities. This sort of training should continue to increase and must be well marketed to PCPs across the state. It is important in these trainings to address not just what medications to use, but also how to compassionately counsel patients in distress, using motivational interviewing and brief intervention tools.

Oklahoma should also incorporate appropriate integrated care training into the various behavioral health professionals' educational programs (psychologists, social workers, licensed professional counselors, etc.). Students should be trained in using integrated care in physical health settings, so that they can be familiar with common physical health conditions and their behavioral elements. In addition to the 50-minute sessions of usual care, students should be trained and comfortable operating within a brief, solutions-focused, evidence-based intervention style. The Anne and Henry Zarrow School of Social Work at the University of Oklahoma is already doing excellent work on this front. Social work students are taught about integrated care, particularly the PCBH model, and can elect to do integrated behavioral health care in a primary care setting for their practicum. This sort of exposure and education on integrated care should continue and expand to other programs as well.

Workforce limitations. Many individuals we spoke with cited the challenges that came with a limited behavioral health workforce in Oklahoma. This was a particular problem for a model like PCBH, which requires an on-site behavioral health specialist. In the Saint Francis system, two Warren Clinic primary care sites successfully implemented PCBH six years ago. However, Saint Francis has been unable to expand this program beyond those initial few clinics, due to insufficient reimbursement for the specialists' work and the lack of available specialists (particularly LCSWs) in the state. For this reason, they have moved to a different model (the "Beehive") as their primary integrated care initiative. Providers in other states, especially in pediatric settings, have found PCBH to be financially sustainable because embedding

behavioral health specialists allows providers to see more patients per day, since the behavioral health specialists can handle a variety of complex, time-consuming behavioral issues or effectuate referrals to specialists. Because of this success elsewhere, it would be worthwhile for Oklahoma to investigate its reimbursement model for behavioral health specialty services in primary care. Improved reimbursement may also draw a larger behavioral health workforce to Oklahoma, as it could increase the pay rate for behavioral health specialists. Currently, Oklahoma ranks last in the 7-state region for compensation for social workers and psychologists, after adjusting for Oklahoma's cost of living.[97] In fact, these two professions average about 75% of what they do nationally.[98]

Others have struggled due to the limited workforce as well. FQHCs, for example, face a particular conundrum. FQHCs can either receive reimbursement via a fee-for-service (FFS) model or a prepayment system (PPS) model, which is a value-based payment model. The PPS model offers a higher reimbursement rate, up to three times the rate received through FFS. However, the requirements for a PPS are more restrictive, and centers cannot use any behavioral health specialists other than fully licensed LCSWs and psychologists. In rural areas especially, these professionals are rare, so health centers end up forced to use the FFS model so that they can employ and be reimbursed for work done by licensed master social workers (LMSWs) who are still in their candidacy years.

The limited psychiatrist workforce is also a problem, particularly in rural Oklahoma. One individual located in southwest Oklahoma reported that there was only one psychiatric nurse practitioner in the area, and the wait to get an appointment was months-long. Beyond that one outpatient psychiatric provider, the next closest specialty clinic with inpatient services was several hours away and for many patients getting there is nearly impossible. The individual explained: "Patients can barely afford their meds, much less take off work and pay for gas and another copay. And that's all assuming they have a car available to get them there." The responsibility for these patients' mental health care often falls to primary care. For this reason, it is even more imperative that Oklahoma provide its PCPs with better training on mental health management and the resources they need to achieve positive outcomes.

One question in our survey of Oklahoma primary care practices conducted with ODMH and OPHIC asked about barriers to providing behavioral health care in primary care. Forty-four percent of respondents said that they experienced difficulty with recruiting behavioral health specialists and forty-six percent of respondents said they experienced difficulty financing workforce expansion and training. Workforce limitations are a significant issue affecting many practices. Interestingly, when asked which of the barriers listed they might like to receive technical assistance for, the option that was chosen most frequently was "how to treat behavioral health conditions in primary care." It seems that more than trying to get help recruiting specialists or financing workforce expansion, PCPs are recognizing that treating behavioral health conditions themselves is more realistic and sustainable.

[97] Healthy Minds Policy Initiative. (2021, January). *Oklahoma's behavioral health workforce: Action areas.* https://www.healthymindspolicy.org/wp-content/uploads/2021/01/HMPI-Workforce-Action-Areas_FINAL_01.08.2116124.pdf
[98] Ibid.

Opportunities for Improvement:
Our primary recommendation for increasing the behavioral health workforce is broader use of integrated care itself. As more primary care providers receive training and work in integrated settings, they will develop the skills and confidence to treat most mild to moderate mental health cases themselves. As they treat more cases, the demand for behavioral health professionals will become more manageable. This potential behavioral health workforce multiplier is another reason why thorough, evidence-based education on the identification and treatment of behavioral health conditions for primary care residents and practitioners is so important.

Beyond expanding integrated care practices, Oklahoma should consider expanding the types of behavioral health professionals allowed to bill within the prepayment system for federally qualified health centers. If LMSWs under candidacy could work with a supervising LCSW and receive reimbursement for that work, that would expand the behavioral health workforce in primary care settings. This would be particularly significant in rural areas, as it could also create pipeline programs which would drive LMSWs (who would ultimately become LCSWs) to move to and practice in underserved rural areas.

While primary care physicians can treat a majority of mild to moderate mental health conditions, severe cases still require behavioral health specialists. A broader investment across the state in training programs for behavioral health specialists of all kinds – social workers, psychologists, psychiatrists – is necessary. Psychiatrists tend to practice where they complete their residencies, so Oklahoma should add more residency positions across the state, particularly in rural areas. Oklahoma could also explore options like identifying funding for the Mental Health Loan Repayment Revolving Fund, created by Senate Bill 773, to incentivize more mental health and substance use providers to come to Oklahoma.

To learn more about Healthy Minds Policy Initiative's recommendations and considerations for addressing Oklahoma's limited behavioral health workforce and its challenges, visit https://www.healthymindspolicy.org/workforce/.

Referral network. In every model, there are cases which are too complex or treatment-resistant to be managed in primary care and require the care of a psychiatric specialty provider. One of the biggest obstacles that PCPs encounter when dealing with behavioral health concerns is gaining access to a reliable specialty care provider to refer to. Many do not have a specialty provider anywhere nearby, and are forced to manage on their own until a patient reaches a crisis point. In one response to a membership survey of ROK-Net Members, a rural primary care practitioner reported:

> "Patients have to drive 50 plus miles for psychiatrist especially one who treats under 18yrs and many times for them to be seen and have eval done it takes months of waiting for appt."

Another illustrated the vicious cycle in rural areas clearly, reporting that:

> "There are just no good resources for mental or behavioral health in the area especially for pediatrics. People who are having issues cannot wait months to get in with psychiatrist to help diagnose and begin med therapy and stabilize condition. Patients end up waiting until in crisis mode and then end up in Tulsa or OKC for inpatient treatment."

Even in urban areas, some PCPs struggle to find specialty care for their patients. One PCP explained that their adolescent Medicaid patients have only one option for inpatient psychiatric care in Tulsa, and if the beds are full they're sent to a different city.

Opportunities for Improvement:
Research shows that anywhere from 60-80% of mental health conditions can be treated in primary care.[99] With easier access to psychiatric consultation, PCPs will become more confident managing that 60-80% of patients from their primary care setting, rather than needing to send them to a specialty facility, especially one that is far away.

In addition to expanding residency and training opportunities for behavioral health specialists in rural areas, Oklahoma should pursue the grant funding available from the American Rescue Plan Act of 2021 to create a child psychiatric access network (CPAN) across the state. The access network provides:

1. Consultation – it would give pediatricians near immediate access to a psychiatrist for a phone consultation regarding their patients with mental health concerns as needed.
2. Resources and referrals – it would connect PCPs to a database of specialists in Oklahoma for their patients.
3. Education – it provides ongoing education of PCPs on evidence-based practices.

CPAN would give rural PCPs an avenue to quick, accessible advice and resources when they have no nearby options. It is also payer-blind, so any PCP with any patient can call and receive immediate support.

Oklahoma leaders should also consider hosting a conference for primary care practices on integrated care. A conference with key players such as ODMH, OPHIC, ROK-Net, and others in attendance could provide participants with educational materials about managing behavioral health concerns in primary care, introduce PCPs to hugely helpful resources (such as OPHIC) to help facilitate an implementation, and would connect PCPs with a broader referral network.

Others struggle to find and coordinate with the referral resources that are available. In an ideal integrated care setting, a PCP has a relationship with a psychiatric specialist that they can refer to as needed. They communicate regularly about the patient, create a shared treatment plan, and when the patient has improved, discharge the patient back into the PCP's care with instructions on how to maintain treatment. However, across the board in Oklahoma, this type of referral network and coordination is lacking.

In our survey of Oklahoma primary care practices conducted with ODMH and OPHIC, lack of good communication with specialty providers was a recurrent theme. When asked: "When more severe cases arise that might require specialty psychiatric care, what is your practice's protocol?" the highest percentage of respondents, 46%, responded that they refer to an outside psychiatrist or behavioral health specialist **with whom they have no relationship or agreement**. Ten percent said they advise patients to find themselves an outside psychiatrist or BH professional on their insurance plan, and 6% said they treat patients onsite without any specialty consultation as best they can.

From our interviews, we learned that some PCPs don't feel they know who to trust to send their patients to, often citing high turnover in psychiatric facilities. Patients return to their PCP frustrated, citing long wait times, different providers every visit, and delays in medication refills. Other PCPs report that discharged patients are sent back with no instructions and no follow up psychiatry or counseling services – just a referral back to the PCP and a request for refills of medications. This lack of any reliable referral network is especially problematic for models like SBIRT, which do not include a psychiatric consultant and rely heavily on "referral to treatment." As one critic noted, "when does [SBIRT] become the wrong thing to do when you don't have anywhere to 'RT' to?"

Challenges with technology. Technology can be a significant resource in implementing integrated care. It can improve the screening experience for patients, allowing them privacy and expediency in working through questions. It can provide electronic screenings that automatically integrate in the EMR and are viewed easily by the PCP before or during a patient encounter. It can support the use of the psychiatric consultant, especially in rural setting, allowing rural primary care to access specialty advice and knowledge. It can connect patients in rural areas to specialty providers that aren't in the area, and make those resources easier for patients to access.

However, for many, this is still inaccessible. Many clinics we spoke with have had trouble integrating their screenings into their EMR. Some who are doing the SBIRT-OK initiative get technical resources and support including tablets and ODMH-developed software for screening, but end up printing the summary off, scanning it into the EMR, and manually entering the scores into the social history section of the chart – allowing for possible errors. The OKPCA has had trouble getting some clinics' integrated care programs off the ground due to an incompatibility between their screening software and the EMR. Some clinics are postponing their implementations for this reason alone, because of the extra work of adding scores manually. This is not an insignificant added task.

For some rural communities, telehealth is much more complicated in reality than in theory. PCPs in rural areas sometimes refer patients to psychotherapy or psychiatric services via telehealth, but this only works if the patient has access to a smart phone and broadband internet, which many lack. One clinic got so desperate during the coronavirus pandemic that they had patients sit in their cars in the parking lot using a nurse's personal phone to conduct appointments while the nurse stood close by. This is obviously unsustainable for many reasons.

Opportunities for Improvement:
The expansion of telehealth can do a lot for rural communities, and is expected to increase accessibility, provide cost-savings, and maintain positive outcomes beyond the COVID-19 pandemic. Many organizations and health systems are working to expand their telehealth resources. INTEGRIS Health, for example, is working to integrate 22 Integris Medical Group (IMG) clinics using telepsychiatry. Primary care provider in these rural clinics will be able to refer their patients to a tele-psychiatrist and patients will have easier, more consistent access to the specialty care they need through telehealth visits. However, with this model of integration, it still falls on the primary care provider to identify the need for behavioral health support in these patients. This further illustrates the importance of quality training for PCPs on identifying behavioral health needs.

Even with the advancements made in telehealth parity and accessibility in recent years (including the passage of Senate Bill 674 during the 2021 Legislative Session), limited broadband access and smart phone usage as well as unstable connectivity make telehealth unrealistic for some. Oklahoma should utilize financial incentive programs to encourage primary care practices to open up a room with a laptop for patients to use for their telehealth visits, both for mental health care and physical health care. This allows patients easier access to the technology necessary, and might even promote better coordination between primary care and specialty care.

To learn about Healthy Minds Policy Initiative's recommendations and considerations relating to telehealth, visit https://www.healthymindspolicy.org/telehealth-in-2021-oklahoma-policy-recommendations/.

[99] Healthy Minds Policy Initiative. (2021, February). *Oklahoma's behavioral health workforce: Medicaid expansion.* https://www.healthymindspolicy.org/wp-content/uploads/2021/03/HMPI-Workforce-Medicaid-Expansion_FINAL.pdf

Financing concerns. Having a financially sustainable model of integrated care is critical for long-term success. However, the peer-recommended programs with which we spoke did not have a clear financing approach that could support and sustain a complete collaborative care, SBIRT, or PCBH model over time. Many of the initiatives we spoke with used grants to fund their integrated care work and it is unclear how the programs will continue if and when the grant funding ends. Some were doing integrated care within the context of Comprehensive Primary Care Plus (CPC+), which does provide some value-based payments but, as mentioned above, usually only incentivizes screening and treatment protocols for a single behavioral health concern. Some felt that hospitals would recognize the benefit of the program once they saw the success of the grant-funded pilot, and agree to absorb the cost. Others saw potential in collecting "small amounts" of reimbursement using billing codes, but hadn't pursued the option yet.

Despite the SBIRT billing codes and educational training from OPHIC on how to use the codes being available in Oklahoma, there is low utilization, and even a lack of awareness, of the codes. Multiple programs we spoke with reported that they did not actually bill the SBIRT codes. This was for multiple reasons. One clinic receives CPC+ funding and treats SBIRT as a way to meet a measure requirement for CPC+, so they do not feel they need specific SBIRT reimbursement. However, when showed the codes, they indicated that they might look into the possibility of billing them. Another clinic reported that they had given up on trying to receive SBIRT reimbursement because it was "too much of a fight" with insurance companies. In their experience, insurers wanted to bundle SBIRT under a more general evaluation and management office visit code, rather than reimbursing the additional SBIRT money. The billing manager found that the additional work and phone calls with the insurers were not worth the SBIRT payment, so they stopped trying. It is worth noting that this clinic does not screen all patients, and might find the reimbursement more worth the effort if they screened universally.

Opportunities for Improvement:
Financing has been an obstacle across the board. While grant funding is an excellent way to try out a new innovative program, it will not sustain the program long-term. It is clear that many separate groups are trying, within their own lane, to find a way to pay for integrated care long-term, but aren't aware of or using their collective power. We recommend organizing a conference for all leaders and organizations working on integrated care in Oklahoma, including OPHIC, ROK-Net, OKPCA, the PCBH provider network, any interested health systems such as Integris or Saint Francis, state agencies including Oklahoma Health Care Authority (OHCA) and ODMH, and the primary insurance payers in the area, including those with managed care contracts. In this setting, all parties could communicate about what obstacles they have encountered, provide suggestions to each other, and discuss solutions. They could work with insurers to guarantee that codes used successfully in other states are turned on by all insurers (in the case of the Collaborative Care CPT codes or the Health and Behavior CPT codes) and codes that are turned on in Oklahoma are appropriately reimbursed (in the case of the SBIRT CPT codes). Insurers can also provide their input on what measures and data collection they need to see in order to move forward with reimbursing integrated care. As we move into more value-based payment models of care, we must ensure that measures are in place to reward and incentivize care for mental health in primary care settings.

An alternative method to ensuring the Collaborative Care, Health and Behavior, and SBIRT CPT codes are active and available in Oklahoma is through legislative action. The American Psychiatric Association provides model legislation for insurance coverage of the Collaborative Care codes, which could be adjusted to include language about the Health and Behavior and SBIRT codes. To view the Oklahoma-specific model bill language, visit https://www.psychiatry.org/psychiatrists/advocacy/state-affairs/model-cocm-legislation.

Summary

Despite the prevalence of mental illness and substance use disorders, many people's conditions go undetected and untreated for far too long, causing worsening symptoms, economic consequences and loss of human life. Integrated care is one possible avenue for increasing access to behavioral health care and improving outcomes. Integrated care utilizes multi-disciplinary teams to monitor and treat both behavioral and physical health needs in a cohesive, evidence-based way. Integrated care can be delivered in a variety of ways, through models including Collaborative Care; Primary Care Behavioral Health; Screening, Brief Intervention and Referral to Treatment; and VitalSign[6], or via a hybrid model that combines key elements of multiple models.

While there are several integrated care initiatives across Oklahoma, many programs and practices struggle with systemic problems that prevent them from implementing full, evidence-based models of integrated care. In order to help these initiatives and practices, we recommend that Oklahoma make some state-level changes to standardize and simplify the process of implementing and sustaining integrated care. These changes focus on improving provider training, incentivizing an expanded workforce, appropriately reimbursing integrated care, enhancing our referral networks, and ensuring evidence-based practices are being utilized.

Integrated care offers a huge opportunity to address unmet behavioral health needs and improve the outcomes for individuals who are suffering and unable to function at their best. It is a great opportunity for Oklahoma and by doing the work necessary to make it successful and sustainable, Oklahoma can begin to "move the needle" on access to effective behavioral health services.