The Greater Houston Behavioral Health Affordable Care Act (BHACA) Initiative: Final Evaluation Report

November 2016

Special thanks to the Houston Endowment Inc., The Meadows Foundation, United Way of Greater Houston Community Response Fund, and the Rockwell Fund, Inc., for their generous support of the BHACA Initiative.

NBHP
Network of Behavioral Health Providers

MHA
Mental Health America of Greater Houston

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EXECUTIVE SUMMARY

In the summer of 2013, the Network of Behavioral Health Providers (NBHP), in partnership with Mental Health America of Greater Houston (MHA), received major funding from three different sources to implement a community-wide education and technical assistance program with the goal of assisting local behavioral health service providers in preparing for the myriad of administrative and practice changes that were imminent in fulfilling the vision of the Patient Protection and Affordable Care Act (ACA). This report presents the results of the three-year evaluation of that effort.

The final evaluation findings for the Greater Houston Behavioral Health Affordable Care Act (BHACA) Initiative presented in this report are based on two major types of data, event attendance records and evaluations for BHACA events, and a set of three surveys conducted with members at the beginning, midpoint, and end of project implementation.

PROJECT OVERVIEW

Goals of the Project

1. We expect every behavioral health organization in Houston to have access to no-cost general information and education sessions that will allow them to assess their preparedness for the ACA. This education will, in turn, lead to increased knowledge/understanding of the ACA across the provider community.

2. We expect each organization that requests technical assistance from NBHP to be ready to meet the requirements for whichever mandate they have requested help.

3. We expect the number and the quality of integrated health care partnerships in greater Houston to grow and for these partnerships linking federally qualified health centers (FQHCs) and other community health clinics with behavioral health providers to successfully plan, implement, and sustain integrated health care services, serving as models for other communities.

4. We expect MHA to gain even more knowledge about the process of integrated health care partnerships and to use that knowledge on as large a platform as possible.

5. We expect NBHP to grow as an organization as the project reinforces to the behavioral health leadership in Houston the importance and value of a committed leadership forum that works together on behalf of the community.

6. We expect the number of low-income clients who are able to access both physical and behavioral health care to increase and for that care to be provided in a seamless fashion that puts the least burden on the clients and improves their physical and behavioral health care outcomes.

Finally, another major emphasis of the model created for BHACA was the utilization of a learning community approach. This implementation methodology calls upon the embedded

resources and expertise within a community—in the case of BHACA we proposed to call upon the staff of NBHP member agencies.

Description of Project Areas/Activities

Programming was implemented within each of the five identified focus areas:

- Enhancing and increasing the delivery of integrated health care (IHC)
- Increasing third party funding streams
- Adopting a certified electronic health record (EHR)
- Developing outcome-based evaluations (OBE)
- Creating a Clinicians' Roundtable

OVERVIEW OF PROJECT ACTIVITIES

Blast

The electronic newsletter, the BHACA Blast, was created to announce upcoming BHACA activities and to share any new information and learning opportunities related to the focus areas of BHACA work. Seventy-five bi-weekly issues were sent to approximately 700 subscribers.

Educational Events

Reach

Over the course of 38 months (October 2013 through November 2016), 78 BHACA events were held and attended by a total of 2,262 individuals representing 34 NBHP member agencies (all except the very newest members), 291 unduplicated non-member agencies, 112 individuals in private practice, and 79 stakeholders.

Value to Participants

Overall, 85% of attendees found BHACA trainings to be very or extremely worthwhile. When separated into feedback on the events by focus area, the scores were also consistently high, ranging from 90% for Outcome-Based Evaluation and Clinicians' Roundtable to 82% for EHRs.

As to the question of how much new knowledge participants felt they had gained, responses indicating a significant amount of new knowledge varied from 76% for Third Party Funding event participants to a low of 52% for persons attending Outcome-Based Evaluation sessions.

Integrated Health Care

The need for education in integrated health care was clearly demonstrated in the baseline survey, in which 78% of NBHP member agencies indicated a desire for support related to the integration of primary and behavioral health care. The target audience for events generally consisted of behavioral health and primary care clinicians and administrators. Overall, the IHC educational events were well received by participants. Eighty-five percent

of participants rated the events as very or extremely worthwhile, and 69% indicated that they had gained a significant amount of new knowledge.

The IHC educational events were enriched by collaboration with other "convening" organizations such as the Harris County Healthcare Alliance, the Houston Recovery Initiative, and the Southeast Texas Regional Healthcare Partnership that coordinates the work of the Medicaid 1115 Waiver for the region.

Third Party Funding

One of the most rewarding and beneficial outcomes of the BHACA Initiative was the one that resulted from our decision to develop and teach a curriculum on "Behavioral Health Billing, Collecting, and Credentialing." Key to the success of this component was the participation of and ultimate impact of the inclusion of healthcare plan staff in the classes.

Certified EHR

In this arena our primary goal was to work with NBHP members who did not have EHRs and to assist them in acquiring an affordable, high quality certified behavioral health EHR system.

Outcome-Based Evaluation

Over the course of the three years of BHACA, BHACA trainings moved agency staff through the stages of evaluation planning and execution from logic model to measurement to data analysis and reporting.

Clinicians' Roundtable

NBHP members requested that we consider providing a component designed specifically for their clinical staff. The events offered by NBHP to the behavioral health clinical community focused on issues such as transitioning to the DSM-5 and Trauma Informed Care and were extremely well-received.

Networking Groups

Informal groups were created for three of the BHACA components, Integrated Health Care, Third Party Funding, and the Clinicians' Roundtable.

Technical Assistance

BHACA staff routinely encouraged NBHP members to reach out for individual technical assistance anytime they needed to. Slightly over 100 requests were made by an array of providers with third party funding and integrated health care receiving the most requests.

Resources

We have used the NBHP and MHA websites as repositories for event materials, webinars, presentation videos, and products created for BHACA.

FINAL MEMBER SURVEY RESULTS

Integrated Health Care

In terms of implementation of IHC, agencies in all categories of behavioral health care are engaged in integrated health care. A larger percentage of responding agencies in the hospital, primary care and mental health clinic, and federally qualified health center categories are integrating care than in the other categories, which consist of various mental health and substance abuse agencies. As far as level of IHC, in general, agencies either increased or stayed at a similar level of integration from baseline to midpoint to final survey. Given the challenges in implementing IHC, and the long-term nature of advancing and sustaining it, the overall indication that agencies either maintained or advanced their level of integration is a positive finding.

Third Party Funding

We can conclude that some increase in third party funding revenues is likely to have occurred for a number of our agencies, but that increase is by no means an across the board commonality. For agencies that focused on this particular issue and had staff that made the reduction of claims denials a priority, they were absolutely successful in reaching that goal. Most important, the real value in this component of BHACA rests in the well-received billing education program/curriculum we developed and will be able to continually update and provide to the state's behavioral health community.

Certified EHR

In general, we found that acquisition of a certified EHR is positively correlated with agency size, with the large hospitals and FQHCs more likely to have systems than community-based mental health and substance abuse providers. And even for those providers that have systems, almost three-quarters reported that they do not use them to their full capacity.

Outcome-Based Evaluation

The fact that 100% of respondents reported collecting client outcome data for both the midpoint and final surveys suggests that NBHP agencies had already attained the desired goal of collecting client outcome data and therefore identical results can be interpreted as evidence of no change. We would argue, however, that this is a case in which the simple tally falls far short of telling the entire story. Instead, we believe there has been change to the more in-depth question of what measures were being used at each time point. If the agencies have changed instruments, then we would hope that those changes were based on the additional information they received through BHACA on validity, reliability, usage by other members, etc. As far as barriers to conducting outcome evaluations, in general the barriers identified at midpoint have decreased.

CONCLUSIONS

Survey Results on Project Impact

With the exception of third party funding, most respondents reported change in perspective in each area with the largest number of respondents reporting change in IHC (90%). Similarly, although not quite as high as perspective results, the activity change goes from a low of 46% for EHR to a high of 79% for IHC. As far as the impact that BHACA had on those perspectives and activities, respondents overwhelmingly indicated that BHACA had impacted their perspectives and activities.

Success as Related to Originally Proposed Goals

1. *We expect every behavioral health organization in Houston to have access to no-cost general information and education sessions that will allow them to assess their preparedness for the ACA. This education will, in turn, lead to increased knowledge/understanding of the ACA across the provider community.*

With a final tally of almost 2300 participants in BHACA events over the past three years and non-NBHP members and private practitioners accounting for over 350 of the entities represented, we believe that we can say with confidence that we provided accessible offerings.

2. *We expect each organization that requests technical assistance from NBHP to be ready to meet the requirements for whichever mandate they have requested help.*

While we are unable to say with certainty that every person seeking technical assistance, either by attending a BHACA event, taking a class, participating in a networking group, or contacting us directly with a specific concern was then able to successfully meet the requirement about which they were asking, we can say that we were able to successfully answer their questions and address their concerns.

3. *We expect the number and the quality of integrated health care partnerships in greater Houston to grow and for these partnerships linking federally qualified health centers (FQHCs) and other community health clinics with behavioral health providers to successfully plan, implement, and sustain integrated health care services, serving as models for other communities.*

BHACA has supported agencies in different places along their IHC "journeys" in both the planning and implementation of integrated health care services. Overall, findings indicate a greater understanding of integrated health care and its importance among greater Houston behavioral health agencies, as well as movement towards more advanced levels of IHC.

4. *We expect MHA to gain even more knowledge about the process of integrated health care partnerships and to use that knowledge on as large a platform as possible.*

The BHACA Initiative has been an invaluable opportunity for MHA Greater Houston. In working with the participating agencies, planning educational events, researching relevant topics, etc., MHA Greater Houston has indeed increased its knowledge of integrated health care, its understanding of the IHC landscape in greater Houston, and its network of IHC contacts and experts.

5. *We expect NBHP to grow as an organization as the project reinforces to the behavioral health leadership in Houston the importance and value of a committed leadership forum that works together on behalf of the community.*

In July 2013, at the beginning of the BHACA Initiative, the organization's membership totaled 24 greater Houston behavioral health service providers. By the end of the BHACA timeframe, November 2016, NBHP has grown from 24 behavioral health provider entities to 39, an increase of 63%.

6. *We expect the number of low-income clients who are able to access both physical and behavioral health care to increase and for that care to be provided in a seamless fashion that puts the least burden on the clients and improves their physical and behavioral health care outcomes.*

While there is no way to show a direct correlation between the learning and agency practice changes resulting from BHACA participation and the specifics of this goal, that learning was targeted specifically at aspects of agency operations change that ultimately are connected to the desired outcomes of the Affordable Care Act.

Process Lessons

The power of real collaboration—Every one of the five areas of work had, at its core, a collaborative process with other community players in every step of its work.

The power of facilitation—We discovered what a major role a massive education/support project can play in facilitating new relationships.

Unexpected Outcomes

This thing called "data"—Our experience with the BHACA evaluation would lead us to suggest that the collection of "good" data is significantly more complicated than one might imagine.

Interpreting data: no simple answers—Our most difficult job was to look at the qualitative survey data, the comments of event participants, and the informal information we gathered along the way because simple graphics weren't telling the whole story.

Telling the whole story—The qualitative examples not only further elaborate on the quantitative findings, but underscore just how significant some of this work has been. The stories behind those numbers are what make the numbers come to life and complete the telling of the story.

The meaning of success—The question of goal achievement in each of the BHACA areas also does not always have a straightforward answer. The overarching goal of the focus area may not necessarily be a one size fits all.

Is it soup yet?—The work of BHACA was implemented over a three-year period. Much of that work was the planting of seeds of knowledge, encouragement to take action, and support to embrace change. It can take a long time for these seeds to come to fruition.

Looking Ahead/Building on the Work of BHACA

Although the BHACA project is formally over, in no way is the work generated by this effort ending. Indeed, it has given NBHP a strong, solid base on which to expand our work in training, technical assistance, and community-building. It has given MHA a strong community base of invested providers to help move its integrated health care work forward into a larger arena that includes public policy.

THE GREATER HOUSTON BEHAVIORAL HEALTH AFFORDABLE CARE ACT (BHACA) INITIATIVE: FINAL EVALUATION REPORT

INTRODUCTION

In the summer of 2013, the Network of Behavioral Health Providers (NBHP) in Houston, Texas received major funding from three different sources to implement a community-wide education and technical assistance program with the goal of assisting local behavioral health service providers in preparing for the myriad of administrative and practice changes that were imminent in fulfilling the vision of the Patient Protection and Affordable Care Act (ACA). This sweeping healthcare reform law and the related legislation that accompanied it (the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Wellstone-Domenici Mental Health Parity and Addiction Equity Act) presented health providers with the most daunting set of revisions in their delivery of care in decades. And for behavioral health service providers who were not included in the financial incentives initiatives offered by the federal government, many of those changes/requirements—and specifically those that were going to require outlays of enormous financial investments—were simply beyond their capacity to meet.

Against this backdrop, NBHP members began the most important dialogue in its almost ten years of existence. While several members had the advantage of being a behavioral health provider as part of a major medical institution (and thus benefitting from the financial benefits and technical training opportunities those systems were able to access through the government), they are also well-aware that their ability to provide quality care completely depends upon having a strong community provider safety net, and thus were no less committed to developing some kind of support effort as were their stand-alone agency colleagues.

As we were just beginning to explore what this effort might look like, we realized that one of the major charges of this new era of health care reform was the integration of physical and behavioral health services—treatment of the whole person—and thus must be included in whatever program model we developed. At the same time, we were aware that over the previous two years, Mental Health America (MHA) of Greater Houston had, with support from the Hogg Foundation for Mental Health and The Meadows Foundation, become the facilitating entity in the state of Texas for the integrated health care dialogue among the state's providers. We realized that it made no sense for us to tackle this particular component without the involvement of MHA, and thus created a collaboration between NBHP and MHA to develop a major initiative which we named the Greater Houston Behavioral Health Affordable Care Act Initiative (BHACA).

In July of 2013, the balance of funding needed for first year support of the BHACA Initiative was received and the three-month planning phase began. The three major funders for the bulk of the project were Houston Endowment, The Meadows Foundation, and the United Way of Greater Houston. In years two and three, Rockwell Fund, Inc. also invested in BHACA. A total of $983,000 from these entities was raised to conduct the array of programs provided in the Initiative.

The final evaluation findings for the BHACA Initiative presented in this report are based on two major types of data sources. The first is a product of the actual BHACA work and consists of the event attendance records and feedback evaluations for BHACA events, ongoing technical assistance logs kept by staff, and unsolicited feedback throughout the course of the project.

The second data source is a set of three surveys conducted with members at the beginning, midpoint, and end of project implementation. The first survey, which we refer to as the "baseline" data, was based on face-to-face interviews with 23 members. These interviews were conducted as guided conversations with a base set of questions serving as touch points for the interview. This methodology resulted in a very rich but inconsistent data set. The remainder of the surveys, which we are labeling "midpoint" and "final," were administered as sets of questionnaires corresponding to the BHACA focus areas.

PROJECT OVERVIEW

Goals of the Project

In our proposals to the original funders, we listed six overarching goals:

1. We expect every behavioral health organization in Houston to have access to no-cost general information and education sessions that will allow them to assess their preparedness for the ACA. This education will, in turn, lead to increased knowledge/understanding of the ACA across the provider community.

7. We expect each organization that requests technical assistance from NBHP to be ready to meet the requirements for whichever mandate they have requested help.

8. We expect the number and the quality of integrated health care partnerships in greater Houston to grow and for these partnerships linking federally qualified health centers (FQHCs) and other community health clinics with behavioral health providers to successfully plan, implement, and sustain integrated health care services, serving as models for other communities.

9. We expect MHA to gain even more knowledge about the process of integrated health care partnerships and to use that knowledge on as large a platform as possible.

10. We expect NBHP to grow as an organization as the project reinforces to the behavioral health leadership in Houston the importance and value of a committed leadership forum that works together on behalf of the community.

11. We expect the number of low-income clients who are able to access both physical and behavioral health care to increase and for that care to be provided in a seamless fashion that puts the least burden on the clients and improves their physical and behavioral health care outcomes.

Subsequently, for the Rockwell proposal, we presented four overarching goals, three of which were slightly different variations of the numbers 1, 2, and 6 (3 and 4 were addressed in the IHC portion and 5 was not included). A new more long-reaching goal was added to the Rockwell request reflecting the progress made thus far and the new realization that this work would stretch far beyond the BHACA timeframe. "Ensure a BHACA Initiative legacy of actively networking professionals who are committed to collaboratively respond to and resolve the challenges of future health reform."

Finally, it is critical to include that, while not stated as a specific goal, another major emphasis of the model created for BHACA was the utilization of a learning community approach. As detailed in the original BHACA proposal, this implementation methodology calls upon the embedded resources and expertise within a community rather than engaging time-limited, outside (and usually expensive) consultants or providing training (also expensive) to a select group of the involved individuals. In the case of BHACA we proposed to call upon the staff of NBHP member agencies. Originally, we proposed this proven approach for the Integrated Health Care component, as this was an area of program development in which this approach had been found to be very effective, including the work of MHA. In the other three areas, we envisioned a slightly different take on the model with the proposed creation of intra- and inter-agency TA teams with whom we would contract to provide training in the project focus areas. While ultimately the actual TA team approach proved unfeasible, we nevertheless relied most heavily on our member agencies' staff and their contacts in the community to provide the bulk of BHACA programming.

Description of Project Areas/Activities

Reviewing the existing research on the most challenging aspects of the Affordable Care Act for behavioral health providers, four major areas of programming emphasis were chosen. Early in the project a fifth area, support to clinical staff which we named the Clinicians' Roundtable, was added at the request of the NBHP membership who asked that we include a component specifically for their clinical staff that would 1) offer training to ensure that their services were in line with best practices and in compliance with the new DSM-5 definitions and ICD-10 codes and 2) do so in a manner that would encourage the same type of networking they have come to value as NBHP members.

As a result, programming was implemented within each of the five identified focus areas:

- Establishing integrated health care (IHC) partnerships (later revised to Enhancing and increasing the delivery of integrated health care)
- Becoming Medicaid credentialed and enrolling clients (later revised to Increasing third party funding streams)
- Adopting a certified electronic health record (EHR)
- Developing outcome-based evaluations (OBE)
- Creating a Clinicians' Roundtable

It is important to make a brief comment on the rationale behind the change in name of two of the foci because the changes are not just a case of relabeling but rather a result of new

learning and realizations as implementation began. In the first case, we originally envisioned that the bulk of the work in integrated health care would be matching behavioral health providers with primary care providers (especially federally qualified health centers) for IHC partnerships. However, as we learned more about the needs of our constituents—both behavioral health agencies and primary care clinics—we realized that partnership facilitation was not what they needed the most. Rather, what they needed was education to support them in planning, enhancing, and sustaining IHC services, regardless of whether those services were provided through a partnership or within an individual agency. As such, we realized that our time and resources would be put to better use by promoting integrated health care more broadly, with a focus on education and collaboration. In the case of the second area, we realized early on that the issue was much larger than just Medicaid funding (particularly in light of the growing realization that Texas was not going to expand coverage anytime in the near future) and the real, much larger charge is helping agencies tap all potential funding sources possible.

STRUCTURE OF REPORT

This report has two major sections of findings, an assessment of the participant responses to the specific BHACA activities themselves and the analysis of the NBHP members' feedback on the impact of the initiative on their agencies.

For the second part that was based on the baseline, midpoint, and final member surveys, much of the information provided is categorized by "agency type." This categorization is one we developed because there is such a wide diversity in the types of behavioral health entities that comprise the membership of NBHP. Providers that are embedded in large hospital systems have very different resources than do federally qualified health centers (FQHCs) than do community-based nonprofits, and mental health service providers have very different policies to which they must adhere than do substance abuse service providers. These operational differences have significant impact on the ability to meet ACA-related goals (e.g., access or financial capacity to purchase an EHR) and thus findings need to be presented in context of the agency environment. Categories were generated by staff, member agencies assigned their "primary" service identity, and those classifications shared with members for their approval.

OVERVIEW OF PROJECT ACTIVITIES

BLAST

The first issue of the electronic newsletter, the BHACA Blast, was emailed on December 19, 2013. The purpose of the communication tool is to not only announce upcoming BHACA activities but to create an information vehicle that includes any new information and learning opportunities related to the four ACA-related areas of BHACA work. The content is national in its scope and thus the recipient roster includes behavioral health service providers all over the country. Of particular note is our series on measurement tools that we began with Blast #14 (July 2, 2014) and ended with Blast #46 (September 30, 2015). Those 32 profiles were archived and placed in a single document that can now be accessed at www.nbhp.org. On November 30, 2016 the last issue of the BHACA Blast will be produced. It will be issue #75 and will be sent to approximately 700 subscribers.

Whenever NBHP and MHA staff are in the community (Houston and far beyond), we are told by practitioners just how valuable this communication effort has been to their work. Recently one of our staff was contacted by a Program Officer with the Hogg Foundation, Rick Ybarra, who wrote, "Thanks to you and the BHACA team for compiling and sending out these precious resources. You don't know how often I hear, 'I don't have time to go online and find out what is going on at the local, state, and national levels.' You provide a most valuable service and I for one appreciate it." Receiving this input from such a knowledgeable and influential source has convinced us to continue producing the newsletter after project completion, keeping the current four issues as central but also expanding its coverage to other critical behavioral health service delivery issues. In the final Blast issue, we will announce to our readers the new and improved post-BHACA edition and ask them for areas they would like to see us include. It is our hope to seamlessly move into this new version.

EDUCATIONAL EVENTS

Reach

Over the course of 38 months (October 2013 through November 2016), 78 BHACA events were held and attended by a total of 2,262 individuals representing 34 NBHP member agencies (all except the very newest members), 291 unduplicated non-member agencies, 112 individuals in private practice, and 79 stakeholders. Because BHACA was intended to support the work of the entire behavioral health community, not just NBHP members, we are very pleased with the number of additional providers we were able to reach beyond our membership. Appendix A presents BHACA chronological attendance data while Appendix B organizes that data by the five program areas.

Value to Participants

For the majority of educational events, participants were asked to complete surveys that included questions regarding how worthwhile they had found the event to be and how much new knowledge they had obtained. Overall, 85% of attendees found BHACA trainings to be very or extremely worthwhile. As can be seen in Figure 1 below, when separated into

feedback on the events by focus area, the scores were also consistently high, ranging from 90% for Outcome-Based Evaluation and Clinicians' Roundtable to 82% for EHRs.

As to the question of how much new knowledge participants felt they had gained (Figure 2), responses indicating a significant amount of new knowledge varied from 76% for Third Party Funding event participants to a low of 52% for persons attending Outcome-Based Evaluation sessions. In short, the majority of BHACA participants felt they had learned a significant amount of new information, and a large majority felt that the event they attended had been at the least very worthwhile. Thus it is interesting to suggest that, even if attendees did not necessarily report that they gained significant new knowledge, they still found the events to be, at the least, very worthwhile.

Figure 1: BHACA Event Participant Satisfaction (found event to be "very worthwhile" or "extremely worthwhile") by BHACA Area

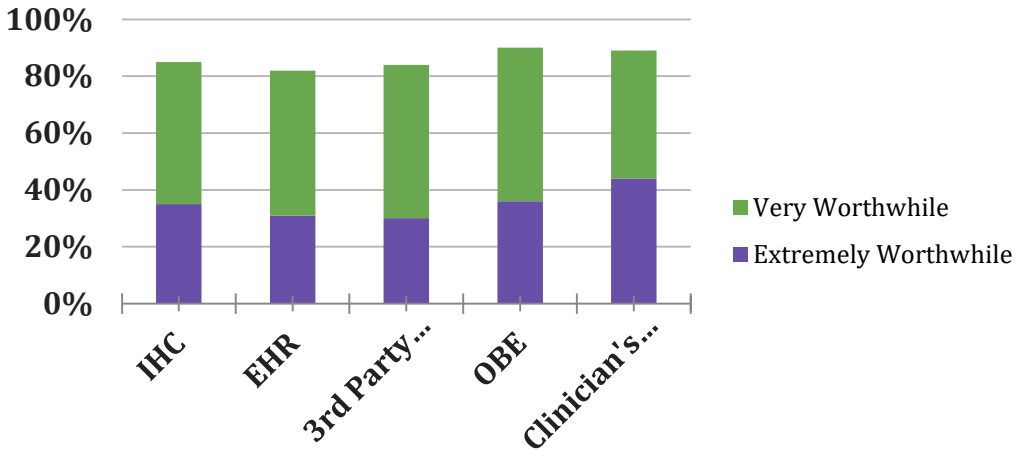
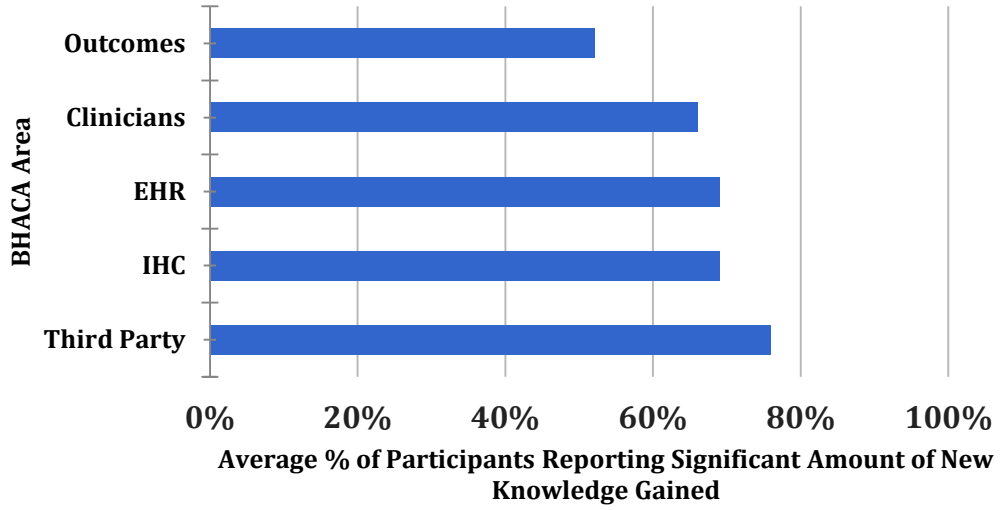


Figure 2: BHACA Event Participant Knowledge Acquisition by BHACA Area



Findings by Area

Integrated Health Care

The need for education in integrated health care was clearly demonstrated in the baseline survey, in which 78% of NBHP member agencies indicated a desire for support related to the integration of primary and behavioral health care. Given the wide range of agency experience with integrated health care, and the many components involved in successfully integrating care, our educational events were diverse in content. Some events, particularly early events, were quite broadly focused, providing general information about IHC and its successful implementation. Other events focused on more specific aspects of IHC, such as financing or screening, or on integration in specific settings or for specific populations, such as individuals with substance abuse disorders. (Note: The event "Get Paid: Financing Integrated Health Care in Texas," which took place on 10/9/14, while formally categorized under Third Party Funding, was actually considered a "joint" event benefitting both the IHC and Third Party Funding components of BHACA.)

The target audience for events generally consisted of behavioral health and primary care clinicians and administrators, with some events geared more towards one subset or another of this broader target audience. A challenge that we encountered in reaching primary care providers was difficulty in providing continuing medical education (CME) and continuing nursing education (CNE) credits. Both NBHP and MHA are certified by the state to provide continuing education units for social workers, licensed marriage and family therapists (LMFTs), licensed professional counselors (LPCs), and licensed chemical dependency counselors (LCDCs). However, neither NBHP nor MHA has the capability to provide CME or CNE credits, which require a much more complex process. We investigated opportunities to partner with CME and CNE providers but generally found that the level of human and financial resource investment required was beyond our capacity. Therefore, our audiences consisted largely of administrators and behavioral health clinicians, with fewer primary care clinicians than would have been ideal.

MHA Greater Houston's previous experience facilitating learning communities on integrated health care had shown us that learning from the experiences of other organizations further along on the IHC "journey" is incredibly valuable. As such, and in keeping with BHACA's focus on peer learning, the IHC events drew largely on local and state organizations willing to share their IHC experiences. To take this type of learning one step further, we organized a site visit to a successful integrated health care site in Central Texas—a partnership between Bluebonnet Trails Community Services (local mental health authority) and Community Health Centers of South Central Texas (federally qualified health center).

The IHC educational events were also enriched by collaboration with other "convening" organizations. For example, we partnered with the Harris County Healthcare Alliance (HCHA) to produce two large educational events—"Behavioral Health Screening in Primary Care Settings: Integrated Health Care Models for Meeting Clients' Real-Time, Whole-Person Needs" (9.9.14) and "Brief Behavioral Health Interventions in Primary Care: Billing Considerations and Clinical Training" (5.8.15). BHACA and HCHA brought complementary

expertise to the table. BHACA brought our knowledge on and network of behavioral health providers, while HCHA brought their expertise in and network of primary care providers such as federally qualified health centers. Similarly, we collaborated with the Houston Recovery Initiative (HRI), a recovery-oriented systems of care (ROSC) collaborative based out of the Houston Recovery Center, on three events—"How Medication Fits into the Pathways of Recovery: A Cross-Training on Medication Assisted Treatment (MAT) as an Option for Substance Use Recovery" (4.17.15), "Addressing Substance Use Disorders in Primary Care: A New Frontier in Integrated Health Care" (4.1.16), and "Implementing a Welcoming, Recovery-Oriented, Integrated System of Care: Applying the Evidence to Practice" (8.5.16). As with HCHA, partnering with the Houston Recovery Initiative enriched our events by bringing their complementary expertise to the table; specifically, HRI brought a deeper level of knowledge on substance abuse and recovery.

Overall, the IHC educational events were well received by participants. As indicated in Figures 1 and 2, 85% of participants rated the events as very or extremely worthwhile, and 69% indicated that they had gained a significant amount of new knowledge. Further examination of individual event evaluation data reveals more detail on the impact of this education. While a full examination of that data is beyond the scope of this report, the 5.8.15 event on "Behavioral Health Interventions in Primary Care: Billing Considerations and Clinical Training" provides an example. On their evaluation forms for this event, 46 of the 53 attendees who completed evaluations responded to the question "What will you do differently in your work as a result of this training?" with a total of 96 very specific changes that participants had identified from the training that they planned to implement in their work. These included changes such as "utilize more MI [motivational interviewing] questioning to address concerns presenting in my office," "start implementing brief behavioral interventions," and "use the 95210 [billing code] during visits."

In addition to the events, an important part of BHACA IHC education took place through our collaboration with the Southeast Texas Regional Healthcare Partnership (STRHP). Based out of Harris Health System, the STRHP coordinates the work of the Medicaid 1115 Waiver for this region (region 3) of the state. Early in 2014, BHACA staff members were invited to present on integrated health care to the Behavioral Health Cohort of the STRHP Learning Collaborative. This initial presentation led to an ongoing relationship, with BHACA staff taking on the leadership of an Integrated Health Care Subgroup of the Behavioral Health Cohort. In this role, BHACA staff introduced the organizations participating in the subgroup to the Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration (OATI), a tool created by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) in collaboration with ZiaPartners, Inc. and MTM Associates. The tool can be used by diverse organizations to assess their progress in integrated health care from a variety of perspectives (e.g., administrative, clinical) and make plans for growth and improvement. In addition to working on the OATI with the subgroup, BHACA staff members had the opportunity to present on the OATI to a larger group of providers at the biannual meeting of the STRHP Learning Collaborative in December 2014. The following feedback from providers indicates the value they found in using the OATI.

- "The OATI caused us to take a 360 degree look at our service model. We are now screening for physical health issues in our clients. We had realized many of our super-utilizers have stage four cancer or cirrhosis of the liver. We are dealing with the chronic inebriate formerly incarcerated homeless population. The medications to manage pain are really expensive, and they are using the substances as a pain management strategy. Our Intake Staff now tracks physical health issues of our clients and management is incorporating physical health into our service model and intervention strategy. The OATI was easy to conduct at the agency level using a PowerPoint for staff to follow along. It was well worth our time."

- An agency that indicated on the final survey that the OATI training was one of the most useful IHC activities has said that such "tools have helped us focus our planning efforts and know what questions to ask. Helped us shape the IHC portion of our SAMHSA MIRRORS application (pregnant postpartum women's services). Helped us make changes to admissions process."

- Another agency indicated that the use of the OATI benefitted their IHC planning process, as it prompted them to incorporate previously unconsidered aspects of integration into their program design. This agency is currently implementing several IHC projects. When asked in the final survey about what other sources outside BHACA had significantly influenced them in terms of IHC, this agency indicated that the STRHP Learning Collaborative had been of influence – thereby pointing right back to the influence of BHACA!

Finally, in considering the impact of BHACA's IHC education in the community, it is worth quoting a BHACA participant, a professor of social work at a local university, who remarked at a BHACA event, "I didn't know there was such a movement around integrated health care in Houston!" Her comment speaks to BHACA's role in building community interest and momentum around IHC.

Third Party Funding

Setting aside the questions regarding just how many NBHP agencies are certified for third party payments and how much actual third party funding they receive, member agencies were very clear that they felt they were not receiving full advantage of this revenue source. While respondents in the baseline survey did not express the need for assistance with becoming certified (only 3 of 23 stated that they were not already certified), they strongly agreed that they could benefit from technical assistance on how to increase their funding from third party sources and were eager to have their billing staff receive assistance with billing problems such as coding errors, denied claims, and most importantly, the upcoming change to ICD-10 codes when the new DSM-5 was adopted. Indeed, even though the vast majority were certified, at the same time, they confirmed that they were not fully utilizing this funding stream due primarily to the many frustrating barriers they hit. In addition, many said they would welcome assistance in becoming accepted on more private insurance panels.

In response to this additional information, the BHACA team decided to move its focus in the component from assistance with certification to "increasing" third party revenues. As a result, one of the most rewarding and beneficial outcomes of the BHACA Initiative was the one that resulted from our decision to develop and teach a curriculum on "Behavioral Health Billing, Collecting, and Credentialing." After extensive research, we came to the conclusion that no training focused specifically on mental health and substance abuse third party revenue streams existed. As far as we could tell, any training that took place occurred informally within agencies as new staff was brought in or by "learning through mistakes" (denied claims).

Initially working with the Center for Healthcare Professionals, Coleman College for Health Sciences and later on our own, we developed just such a curriculum. In a one-year period of time (September 2014-September 2015), NBHP conducted a total of 6 blocks of billing classes reaching at least one billing staff person from 23 NBHP agencies and a total of 129 billing staff from 64 agencies (the 23 members and 41 nonmembers). A revised single day session conducted in Austin in July 2015 attracted 36 participants, who in turn reported 100% satisfaction in the worthwhileness of the session and receipt of new knowledge. This event was noteworthy because, based on the enthusiastic response to that condensed version, the course was revised to be conducted as one full-day session.

The overwhelming, enthusiastic response of billing staff (84% of students deemed the class very or extremely worthwhile) to this unique educational offering was obviously a huge accomplishment for this extremely labor-intensive investment. What was not expected, however, was the participation of and ultimate impact of the inclusion of healthcare plan staff in the classes. Ultimately we involved four of the region's Managed Care Organizations (MCOs) in one or more third party activities. One NBHP agency expert who co-taught many of the classes actually moved to the other side of the table when midway through the project she took the position of Vice President, Network and Vendor Management for one of the state's largest MCOs.

The most significant relationship, however, was established with the relatively new vendor for our region's Medicaid behavioral health MCO through Community Health Choice, Beacon Health Options. Little did we know that Beacon had faced major challenges moving into the Texas market both from the very different way that Texas handled managed care from its other locales and from having a more stringent set of standards than Texas providers were used to. The two Beacon primaries decided to enroll in the first set of billing classes in hopes of gaining additional information about the Texas landscape and challenges. What they and the billing staff students gained from this participation was far beyond what anyone could have imagined. Beacon Health Options Manager of Provider Partnerships (the vendor for Community Health Choice Medicaid) Daniel Ramirez has given us permission to quote his unique and thoughtful perspective on the impact of BHACA on their work as an MCO.

> *The BHACA billing class in the fall of 2014 unexpectedly established a much needed communication channel and pseudo-forum for Beacon and the provider community, which continued even after the initial first contact between us and the providers. The*

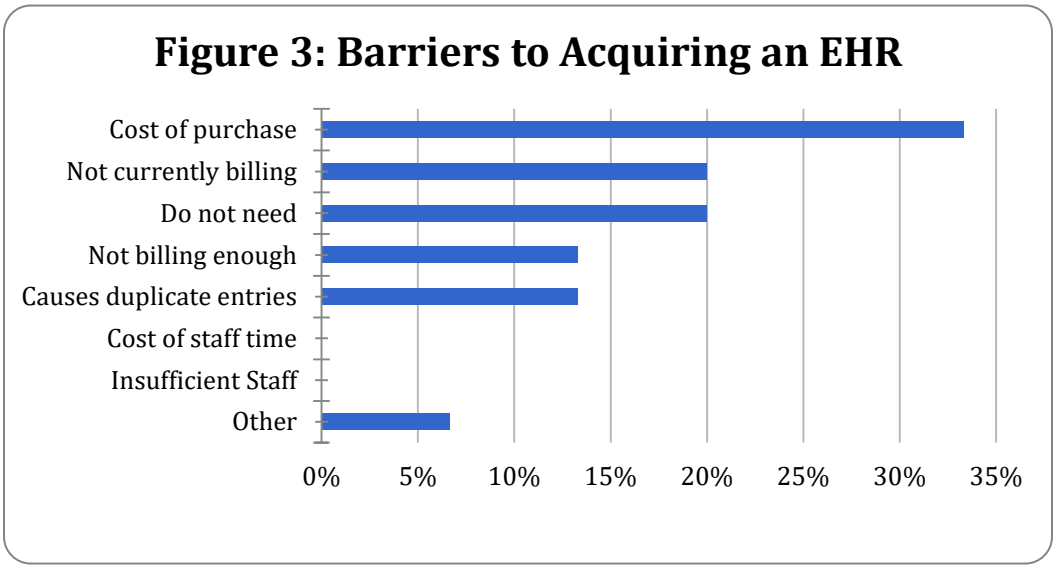
BHACA classes and meetings provided almost like what was a common ground that both Beacon and providers could engage each other on. My role was impacted by being afforded the opportunity to discover and be approached by providers who told me their unresolved Beacon issues. Had this never occurred, we would have never been aware of such issues existing in our local market. We had a chance to redeem the faith that had been lost in Beacon by hearing the BHACA members' feedback. ***The "forum" BHACA provided indirectly also afforded my role the opportunity to engage in provider education in helping providers to understand how Beacon and managed care works in general.*** *I was able to hear a claim issue and what it looked like on the provider end and then share what it looked like on Beacon's end. The disconnects of what happened between point A to point B could finally be pieced together, understood and collaboratively resolved. My prior experience at Texas Children's Health Plan as a Utilization Reviewer (and prior to that a reviewer on the provider side), now combined with a growing experience base and skill set in claims resolutions, in part thanks to BHACA, also aided in helping to educate BHACA providers in understanding the authorization and claims process from a managed care perspective. BHACA's forum also aided in the spreading of mass provider communication to the provider community when needed.*

The BHACA initiative has helped significantly to influence how we conduct Beacon's role here in this market and Ben and I's role as account managers. On my arrival in September 2014, 80% of provider issues were billing and claims related. The client health plan CHC had a near 50% denial rate. ***Fast forward 2 years later, post BHACA, and now only 30% of provider issues are billing and claims related. CHC's denial rate now averages at 10% or under for behavioral health.***

I tend to use analogies to describe situations and if I had to use one here on describing the role and impact BHACA made on myself and Beacon, it would be that of like what and why the United Nations was established. … Just as one of the UN's primary purposes is to prevent another world war from occurring by providing a forum to discuss and resolve issues between nations, BHACA served in a similar capacity with its forum, having a positive impact in helping to bridge the gap in understanding between Beacon and the provider (emphasis ours).

Certified EHR

As detailed in the member survey section below, a significant number of NBHP member agencies did not have certified EHRs at the beginning of the project. And as clearly shown in that data, this absence was most problematic to smaller mental health nonprofits and substance abuse providers. In the baseline survey, NBHP members who did not have a certified EHR were asked to identify what the largest barriers were to acquiring an EHR for their agency. Figure 3 below shows that there were two over-riding issues for providers, the cost of the system and the belief that they did not currently need an EHR either because they were not currently billing or not billing enough to justify the adoption.



As the BHACA staff began to do more research on the impact of failing to purchase an EHR system, the evidence made it clear that our member agencies were minimizing the impact that opting out of adopting a system would have on their operation. As we argued in our original proposal, providers without certified EHRs will likely not be viewed as desirable IHC partners, not be able to participate in Health Information Exchanges, and have far more difficulty providing the kind of quality outcome data required for third party reimbursement of services. And those third party payers are quickly moving towards accepting only electronic reimbursement claims. With meeting the goals/requirements of healthcare reform in large part dependent on adequate electronic record-keeping, we deemed it our primary goal in this arena to educate those NBHP members who fell into this non-participant category and to 1) work with them to understand the importance of this reform and 2) ultimately assist them in acquiring an affordable, high quality certified behavioral health EHR system.

From the baseline data, we identified 10 member agencies that would fit this category and asked them if they would be interested in working together to see if we might come up with a plan for the purchase of an EHR. All 10 agencies agreed to be part of an EHR workgroup. At this point we contacted the National Council for Behavioral Health and, through them, contracted with an expert consultant. Amy Machtay with Boughtin Orndoff Consulting in North Carolina came in July 2014 and spent three days with these agencies. The first day was an intensive educational session on the functionalities of EHRs and the internal needs assessment work that must be done to determine what each individual agency's highest priorities and needs were in an EHR system. She then spent the next two days visiting each of the 10 agencies to gain more insight into their unique operations. At the end of the consultation process, each agency received a report detailing her conclusions and recommendations on their particular needs and what their likely costs would be to purchase and implement a system.

At this point the BHACA staff determined the next step for these providers would be to explore possible EHR acquisition through one of two possible routes, 1) identifying an

NBHP member who would be willing to allow one or more of these member agencies to purchase "seats" in their system or 2) finding a vendor who would offer a group contract to this EHR "workgroup." Our hope was that vendors would be drawn to the concept of working with a group of agencies who could not afford their product on their own and respond to our invitation with a creative, affordable model that they could then market to other communities based on successful implementation in Houston. After review of systems in use by other members and exploration of option 1, we determined that this scenario was not viable. However, in this investigative process, we were drawn to one member's EHR selection and purchase process. This particular agency is the one mental health outpatient clinic in our membership that independently acquired a system. As an outpatient clinic with a relatively small budget, their needs correspond very closely with those of the agencies in the workgroup. On our behalf, the Director of Operations (the professional point person at this agency for the EHR) had an appointment with the vendor CEO and major program staff. The result of this meeting was a very exciting and affordable contract proposal, which we were able to present to the workgroup in October 2016.

At the time of the October meeting, 7 of the original 10 agencies were still in the workgroup. It is important to note that, with one exception, this attrition is actually a positive outcome. The exception is that one of the agencies has, sadly, been closed due to lack of funds. Of the other two, one of the agencies has decided to stay with the clinical data management system they are already using but stated in their final survey that the workgroup and consultation had been influential in "strengthening our perspective that we need to use more of our EHR (their words) capabilities and we are moving in that direction." The final agency is an "unexpected" positive outcome as their result is approval of a grant request specifically to purchase a new data management system. After a very detailed examination of this agency's specific work, existing situation, and data needs and usage, our consultant concluded that they did not need EHR capabilities but rather needed a new data management system. Being able to report this national consultation, the information they had gained through the workgroup, and reporting the consultant's conclusions, the agency was recently funded for a new data system purchase and first year of implementation cost support.

As far as the 7 agencies that are continuing on this journey, at the October meeting the workgroup agencies' staff were able to see a demonstration of the system and have their questions answered by the vendor client agency's Director of Operations. We then presented to them the proposal the vendor had offered and (via phone) had their questions answered by the vendor program staff. In their evaluations, all 7 providers said they wanted to keep pursuing this option. Several felt they needed more information (understandably), but this is a very encouraging response. In order to make sure we are performing due diligence, we are soliciting letters of interest from behavioral health EHR vendors that have interest in obtaining or increasing Texas clients. This query will outline the parameters we are seeking in a group contract (based on the very attractive features offered by the current vendor candidate), and if we have other interested vendors respond, we will engage in a detailed RFP process. If other vendors do not respond, we will continue to dialogue with the current vendor, fleshing out the contract in detail and having them come to Houston for a demonstration/further questions and negotiation.

In summary, if we are able to connect the majority of our members who currently are unable to obtain certified EHR systems with the means to do so, then this will stand as one of the major accomplishments of the BHACA Initiative. Moreover, if we are successful in working with a vendor to develop a successful model for small agency group contract purchase, we could very well set a new direction for the industry in making this vital component of healthcare reform a reality to community-based behavioral health providers everywhere.

Outcome-Based Evaluation

In the baseline survey, outcome-based evaluation was the area that received the second highest number of agencies saying they would like training (70% of respondents). To respond to that need, we contracted with Dr. Toni Watt, full professor at Texas State University Department of Sociology, to work with us throughout the course of the project. Starting with the earliest BHACA events, Dr. Watt provided a total of five technical evaluation sessions that began with an overview of the entire evaluation process and the critical importance of its inclusion in a provider's service delivery planning, especially with the change in reimbursement criteria from fee-for-service to quality of care. Over the course of the three years of BHACA, Dr. Watt moved agency staff through the stages of evaluation planning and execution from logic model to measurement to data analysis and reporting. Most popular were the two hands-on sessions conducted on logic models specifically for NBHP members. A total of 42 staff from 13 agencies worked in teams of 3-5 persons creating specific logic models for programs they were currently working on while receiving one-on-one, face-to-face instruction and feedback from Dr. Watt. We ended the block of outcome-based evaluation sessions with a presentation on one of the newest trends in evaluation, "Data Visualization," by the nationally recognized Evergreen Evaluation and Data out of Michigan.

It is interesting to note that this events focus area had the highest percentage of very and extremely worthwhile responses from attendees (90%) while having the lowest level of attendees saying that they had gained a significant amount of new knowledge (52%). This seemingly contradictory outcome would suggest that, even if participants do not feel they have gained a tremendous amount of new knowledge, they can still find a learning activity to be very worthwhile. Moreover, it makes sense for this dichotomy to occur in this specific focus area. The other three areas tackled issues that were likely new to attendees or at least offered significant new information beyond their existing level of knowledge, and one of our primary objectives in those areas was to increase their knowledge.

Outcome-based evaluation is a topic that behavioral health provider staff are likely to have been first introduced to in their undergraduate work, delved into in greater depth in graduate programs, and routinely received refresher or update opportunities throughout their careers. So it is easy to see that much of the actual information received might well be repetitive. What we did working with Dr. Watt in BHACA, however, was to make sure to present that information in ways that connected this learning specifically to their agencies' work agendas. For instance we didn't just talk about the structure and process of creating a logic model, we had them sit down with their colleagues and actually create one or more

logic models in a setting where they could call upon experts and leave with a completed logic model literally in their hands. Likewise, when focusing on data analysis, Dr. Watt made herself available to assist participants in manipulating their data within the context in which they were comfortable (e.g., Excel software). In short, we believe it is safe to say that the judgment of just how worthwhile an activity was is based not only on new information acquired but also on the utility of the information to the individual's work.

Clinicians' Roundtable

As described in the Project Areas section above, as the BHACA implementation was coming together, NBHP members requested that we consider providing a component designed specifically for their clinical staff. Responding to that request, we developed the "Clinicians' Roundtable." We knew that the number one item on clinicians' lists of professional concerns was transitioning to the DSM-5 and its companion coding system, the ICD-10. Thus the first event we held (and which we actually had to repeat in response to provider request) was focused on these two game-changing updates.

Because we felt that clinicians currently working in this rapidly changing post-ACA environment were uniquely positioned to know exactly what they and their colleagues needed in order to stay "on top" of their field's newest trends/practices/etc., we invited four senior clinicians from member agencies to serve as an advisory committee to the Roundtable component. Because of their extremely generous donations of time and energy, the events offered by NBHP to the greater Houston community behavioral health clinical community have been extremely well-received, having focused on not only timely issues but also subjects that would not have appeared on the agendas of the agencies/hospitals that offer continuing education (CEU) credits to social workers, licensed professional counselors, and licensed marriage and family therapists.

One of the most well-attended and received trainings was on Trauma Informed Care (TIC) and was a member-only training. We invited the two most well-known certified TIC trainers in Houston and worked with them to create a unique and what proved to be very effective approach to a four-hour introductory workshop. Because TIC is not just a therapeutic approach but, in actuality, must involve the entire organization in responding as a trauma-informed care entity, we structured the session as a team event asking each agency to select a four-person group including the NBHP member CEO (or their representative) as well as clinical staff. Not only did we agree with our experts that leadership must understand and embrace this conceptual framework, but it is also vital that they recognize the toll that providing therapeutic services to persons with trauma-related issues takes on their clinical staff, and they must include clinician self-care in their agency's agenda in order to support their staff. This directive on team participation and make-up was well received and in the two sessions (again we had to repeat the event due to popular demand), we reached 75 staff from 18 member agencies. Not only was the knowledge deemed extremely important by the agencies, but conversations began among members that are already developing into exciting post-BHACA activities.

One of our last sessions, "Being a Clinician in a Legal World" is a prime example of the significant impact that our advisory committee made on our ultimate programming choices. Not only was it proposed by one of our advisory group members, it would never have been on the radar of BHACA staff. For this session we called upon attorneys specializing in mental health law as well as Judge Brock Thomas who serves as Harris County's Mental Health Court Judge to address such issues as testifying, responding to subpoenas, complying with confidentiality and HIPAA laws, and liability coverage. The enthusiastic response to this session also points to the fact that sessions of value to clinicians are not just those focusing on clinical techniques and concerns. In the final analysis all but one of the 90 participants rated it very or extremely worthwhile, and a large number of attendees requested that we consider making this session an annual event.

NETWORKING GROUPS

Integrated Health Care

Early in the BHACA Initiative, an initial attempt was made to establish a networking forum for integrated health care. Two "Open Discussion Meetings" were held, but did not generate a great deal of interest, so no additional such meetings were scheduled. At a later point in the project, a BHACA participant suggested that BHACA create a networking group for behavioral health clinicians practicing in primary care settings. BHACA staff suggested that the group also include administrators and other interested parties, and thus the Integrated Primary Care Behavioral Health Networking Group was born. Since February 2015, the group has met five times (approximately quarterly), with attendance ranging from 7 to 19 people. The format usually consists of a brief, informal presentation on a relevant topic followed by discussion. While no formal evaluation of the networking group has been conducted, participants' involvement in the meetings as well as comments in the final survey suggest that it has been of value.

It is noteworthy that it was not until later in the project – when more activity around integrated health care had taken place – that an IHC networking group proved to be of interest to participants. The early "Open Discussion Meetings" were perhaps *too* early; it was not until further down the line when enough interest had been generated by other events that a networking group proved valuable. The fact that it was a participant, as opposed to a BHACA staff member, who suggested the networking group, also indicates that the time was then ripe for this type of group. In keeping with the collaborative spirit of BHACA, the participant who initially suggested the networking group has continued to work with BHACA staff on planning the meetings (even though she herself has since moved to San Antonio). As part of its continued work in integrated care, MHA Greater Houston plans to continue to host this group after the end of the BHACA Initiative. BHACA staff have also recently learned that the BHACA participant who helped start the networking group is now starting a similar group in San Antonio, adapting BHACA's marketing material for use by the San Antonio group.

Third Party Funding

Because of the interactive nature of the formal billing, coding, and credentialing classes, strong relationships formed among the billing class participants. Their response was enthusiastic when we asked if they would like to continue meeting on a regular basis. Immediately following the first class sessions, which ended in December 2014, we began holding networking meetings. Between January 2015 and April 2016, we held some type of billing gathering almost every month. In nine of those months, the meetings were actually informal networking sessions where people brought questions and concerns they had to share with and receive input from others in the group. For most of those meetings one or more provider representatives from MCOs were also in attendance.

Through the first eight months of meetings (5 sessions) attendance stayed consistent at about 7-9 people. However, as we moved into the fall, attendance dropped off to 4-5. Because our original Project Manager who co-taught the billing classes left after this drop off, we can safely say that her exit was not the reason behind the decrease. However, when we restarted the classes in the spring of 2016, the attendance at the two we held remained at this lower level. We believe there are several factors behind this. One, the last billing classes in Houston were held in September 2015, so there were no additional people coming in as potential participants. Two, we have evidence to support the fact that, when the graduates had specific questions or problems they reached out to each other and directly to the provider representatives at the health care plans whom they now felt comfortable in calling upon. Recently Beacon staff mentioned that the number of NBHP members reaching out to them had increased dramatically since the classes.

(Postscript to the outcome on this component: We decided to try one more time to pull this group together prior to the formal end date of BHACA. Beacon Health Options graciously underwrote the November lunch meeting, and we were delighted to have 10 billing staff from 7 NBHP agencies and 4 provider relations staff from 3 health care plans in attendance. During the first half hour, while attendees ate and chatted informally, we watched as numerous business cards changed hands all around the table. During the formal discussion, both provider staff and payer representatives initiated challenging and important discussion topics. For instance, this meeting occurred two weeks after the start of the STAR Kids program and the representatives from two of the STAR Kids health plans provided an overview to the new program and a timeline for the transition process. What we heard from the group at the end of the session was that they absolutely wanted to continue meeting, that the time and structure of this session were highly preferable to earlier formats, and that they would be using each other as resources between the quarterly meeting schedule they agreed upon. The most interesting and important single piece of information we received was that the original purpose behind the formation of the networking group—to answer questions and receive assistance with specific problems they encountered in their billing work—is apparently no longer a need, but continuing to meet to discuss issues of mutual concern is. One of the health care plan representatives observed that when BHACA started he constantly received claims questions but he guessed it had been over a year since he had fielded any and the claims being submitted were

moving through just fine. He paused a moment and reflected, "You know, this project really did exactly what it was supposed to do."

Clinicians' Roundtable

As a result of discussions held with the Clinicians' Roundtable Advisory Committee, 3 informal events were held for clinical staff members of NBHP agencies. As with the NBHP Billing Networking group, response to these events was, at best, spotty (20 participants at the first, 11 at the second and 9 at the third). Because of the excellent response we had to the training events for these professionals, and the comments we received from attendees at the three events were very positive, we were puzzled as to the lack of carry-over to an opportunity to interact with colleagues from other agencies in a much more informal setting. In follow-up conversations with our advisors, however, we came to the conclusion that whenever clinical staff carves out time away from their normal duties, it generally means rearranging client appointments or losing precious time for other essential tasks directly related to providing clinical services (e.g., report writing, staff meetings, etc.). For an educational session, especially when CEUs are offered, blocking time away from the office can be readily justified. However, leaving the office an hour early at the end of a workday to "network/socialize" while worrying about traffic, picking up children, etc. is simply not something they are willing to see as a high priority. In short, these professionals are carrying huge caseloads. Moreover, their agencies likely have a waiting list of individuals in critical need of services and being absent from potential appointment times and the related work is hard to justify.

TECHNICAL ASSISTANCE

From the beginning of BHACA, staff routinely encouraged NBHP members to reach out for individual technical assistance anytime they needed to. While such assistance did not ultimately consume a large percentage of staff time, members (and other providers in the community) did reach out with questions. The BHACA Technical Assistance Log shows that a total of 104 requests were made by an array of providers. Of those 104 requests:

- 50 or 48% involved Third Party Funding
- 33 or 32% involved Integrated Health Care
- 6 or 6% involved Electronic Health Records
- 5 or 5% involved Outcome-Based Evaluation
- 10% involved two or more areas

This technical assistance ranged from answering quick phone calls or emails to conducting research on behalf of a provider to presenting formal presentations to NBHP member agency staff. For those questions that staff were unable to readily answer or were not able to answer through further research, others in both the local community and the field were called upon. It is of note that no expert we contacted ever declined our request, and, if they asked about the BHACA Initiative, all were enthusiastic in their support and belief in our work. Most importantly, invariably after completion of a technical assistance task, BHACA staff received thanks and praise for their efforts. (See Appendix C for examples of typical

requests and samples of the type of detailed assistance that was provided.) Keep in mind that the BHACA TA Log only records the requests that came directly to BHACA staff. We have no way of knowing just how many staff reached out on their own to colleagues at other agencies, event presenters, and other resource people that they were introduced to through BHACA.

RESOURCES

Website

We have considered the NBHP website a critical part of sharing the BHACA information since the earliest activities. A large portion of the information generated from the project is available to the public under the BHACA tab. In addition, we have always seen many of the aspects of the BHACA Initiative as membership benefits and thus we have also created a member only section on the site where we have a number of products that we created specifically for the benefit of NBHP members. Our website builder provides statistics only for the last 12 months. However, even with that limitation, we are able to report that for the time period July 1, 2014-June 30, 2015 we had 4,281 users and 9,300 page views. The corresponding numbers for October 1, 2015-September 30, 2016 are 10,941 and 35,682 respectively, a clear and notable increase.

Public Access: Event Materials

In general, any informational materials in either handouts or PowerPoint presentations are placed on the nbhp.com website as soon as the event is over. Webinars and issues of the Blast are archived as well. Moreover, we used a small portion of our grant funding to video record several of our largest events. The following recordings of live events and webinar recordings are available online:

- Being a Clinician in a Legal World
- Addressing Substance Use Disorders in Primary Care
- Rebooting Evaluation: From Tedious Exercise to Essential Change Agent
- Getting Paid: Financing Integrated Health Care in Texas
- Behavioral Health Screening in Primary Care Settings
- Physical Health 101: Understanding Physical Health for Behavioral Health Providers
- Privacy and Integrated Behavioral Health—Special Considerations Under HIPAA and Part 2

Because MHA has taken the lead on the IHC portion of BHACA, integrated health care resources are placed on the mhahouston.org website.

In addition, we created a page dedicated to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As more information regarding MACRA is released, we are including those articles and press releases in our Blast and also adding them to the MACRA page on the website. This page allows viewers the chance to find up-to-date information on a rapidly changing front in one place.

Member Only Access

As a benefit of NBHP membership, we have created a password accessible, member only page. Here we have placed informational tools created by BHACA staff including a compilation of common behavioral health codes and modifiers, NBHP points of contact at regional healthcare plans, an accreditation guide, and a guide to getting on MCO panels. In addition, in response to growing emphasis on quality of care, we have created a section on outcome measurements that contains National Quality Forum (NQF) measures tracked by member agencies, NBHP measures tracked by national programs or initiatives, a fully annotated directory of outcome measures, and a list of the links to specific measurement tools.

FINAL MEMBER SURVEY RESULTS

RESPONSE RATES

Knowing the challenge of obtaining high response rates on surveys, it should come as no surprise that our experience was equally if not more challenging than that of other research efforts given that we were asking a CEO or ED to complete a multi-part questionnaire that relied on them to seek answers from other staff when they were unsure of the correct answer. With much cajoling, begging, and even bribing, we ended the evaluation with acceptable response rates.

For the baseline evaluation, 20 of the 23 members at the start of BHACA were interviewed along with three members who joined during the survey phase. (This excellent rate of response is due solely to the fact that the survey was conducted as a face-to-face interview.) For the midpoint interview, which was a set of 5 very lengthy hard copy questionnaire sets, 23 of 25 members who were asked to complete surveys did so for a response rate of 92%. Note: Of the 29 total members at midpoint (which was prior to the Year 2 data in Table 3 below), 3 were inactive and one is not a provider. And for the final survey—which was a much shorter version of the midpoint one and distributed by either the online tool Survey Monkey or hard copy—28 of 33 members (of the remaining 6 members, 2 were inactive, 1 is not a provider, and 3 joined after the survey was completed) provided responses for a response rate of 85%.

In spite of these impressive response rates, actual analysis of the data led us to conclude that we must make some additional comments regarding data accuracy. In fact for a number of questions, we actually went back and re-contacted some members to ensure accuracy (and in the case of the EHR acquisition table to obtain a 100% completion rate). As just noted, the members of NBHP were asked to complete the survey and reminded repeatedly throughout the questionnaire documents to access staff who were directly involved in BHACA activities to assist them with answers in specific sections related to their particular involvement. We even gave each agency a summary sheet listing every staff member that attended an event so they would know whom to call upon for each of the focus areas. At the end of each section, respondents were asked to name the staff that assisted in the completion of that section.

In reviewing the completed surveys, it is clear that many of the members did not seek out other staff but rather relied on their own perceptions to answer the questions. Further, there is inconsistency across the midpoint and final surveys as to who completed the survey. In some instances, the member was new to the group since the midpoint survey. We also have evidence that the members were much more diligent about reaching out for assistance in the final survey than they were at midpoint (our conclusion from the sign-offs on the instruments). Regardless of those issues, there was also a year and a half gap between administration of the midpoint and final surveys, and respondents were not able to review their earlier answers. Not having this comparison data as a reference, we have no idea if their later answers are even comparable. Thus in the instance of third party funding, for example, we had several cases in which the agency reported a larger percentage of their revenue was from third party payers at midpoint than at the end. On

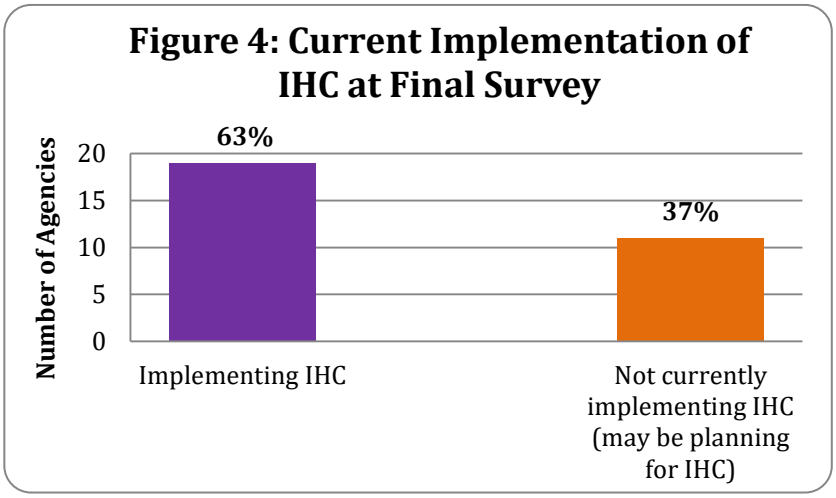
the subsequent question of whether or not their percentage of revenue from third party payments had increased or decreased since BHACA, they replied that it had increased.

FINDINGS BY FOCUS AREA (in comparison with baseline, when possible, and midpoint evaluations)

Integrated Health Care

Implementation of IHC

As shown in Figure 4, of the 30 agencies that provided IHC data at the final survey, 19 indicated that they are currently integrating care, and 11 indicated that they are not currently integrating care. Of the 11 that are not currently integrating care, most are planning for integrated care, though the level of planning ranges from quite specific and actionable plans to non-specific consideration of IHC as a future option. Among the 19 organizations currently integrating care, variety exists regarding what types of services are being integrated. All 19 agencies are integrating at least two of three main types of services—mental health, substance abuse, and primary care; some organizations are integrating all three. A few organizations are integrating some other additional service(s) as well.



Data on current implementation from the midpoint survey is very similar to that from the final survey. Two organizations that indicated that they were implementing IHC at midpoint indicated that they were not doing so at the final survey. One of these agencies had an IHC partnership at midpoint that no longer existed at the time of the final survey. As for the other agency, further examination indicates that the agency did not change its service provision from integrated to non-integrated. Rather, the agency appears to have changed its understanding of what it means to be integrated. At midpoint, they considered their services to be integrated, but at the final survey, they considered those same services not integrated.

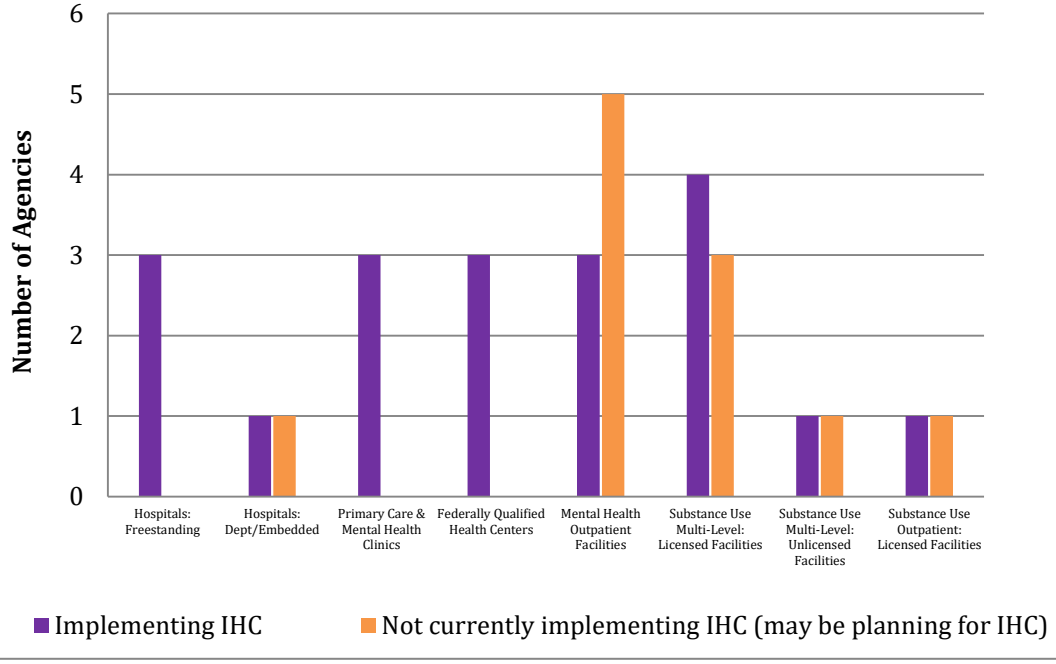
During the in-person interviews conducted at baseline, agencies were asked whether or not they were integrating care. Twenty agencies in total answered this question at baseline and also provided IHC data at final survey. Of these 20, ten indicated that they were providing integrated health care at baseline and final survey. Three indicated that they were not providing integrated health care at baseline nor final survey. One was not providing integrated health care at baseline but had developed integrated services by final survey.

Interestingly, six agencies indicated at baseline that they were providing integrated care, but at final survey indicated that they were not. Two of these are the agencies mentioned above in the discussion of midpoint vs. final survey results. Knowledge of the other four agencies suggests that these agencies were not offering integrated care services at baseline that they ceased to offer by final survey. Rather, these agencies were not actually offering IHC at baseline. They were likely offering services—such as referrals—that they interpreted as integrated care when answering the question at baseline. These agencies later realized that the services they were offering did not actually qualify as integrated health care. BHACA educational efforts—particularly early on in the initiative—emphasized what it truly meant to provide integrated care, likely contributing to this change in understanding.

Similarly, it is possible that some agencies that are integrating care now (at final survey) were not doing so at baseline, but indicated that they were doing so, due to a lack of understanding at the time about what it actually meant to integrate care. Therefore, although the data seem to indicate that agencies (with one exception) that were not implementing IHC before BHACA did not begin to implement it during BHACA, it is possible that a greater number of agencies developed IHC during BHACA than indicated by the available data.

In understanding why an agency might or might not choose to develop IHC, it is helpful to consider agency type. Figure 5 further breaks down data on current implementation (at final survey) by type of agency.

Figure 5: Current Implementation of IHC at Final Survey, by Agency Type



As Figure 5 demonstrates, agencies in all categories are engaged in integrated health care. It is notable, however, that a larger percentage of responding agencies in the hospital, primary care and mental health clinic, and federally qualified health center categories are integrating care than in the other categories, which consist of various mental health and substance abuse agencies. There are two very plausible reasons for this discrepancy. One is that the integration of behavioral health into "physical" health care facilities—such as hospitals and primary care clinics including FQHCs—is a longer-standing model of integration. The integration of "physical"/primary care services into behavioral health facilities—sometimes referred to as "reverse integration"—is a newer model that has not been as widely studied or implemented. Secondly, as in other areas on which the BHACA Initiative focused, facilities such as hospitals and federally qualified health centers have often had access to resources, whether financial or otherwise, to assist their efforts, whereas such resources have been scarcer for behavioral health agencies. Such circumstances may make behavioral health agencies less likely to decide to integrate care. This makes it all the more commendable that various behavioral health agencies—at least one in each behavioral health agency category—are nevertheless integrating services.

Level of IHC

In considering advancement in IHC, it is important to consider not only whether agencies are implementing IHC, but also the degree of integration within agencies. It is very possible for advancement in IHC to take place by increasing or deepening the degree of IHC, even without development of new IHC programs. It can be useful to think of integration as existing on a spectrum, such as the six-level framework created by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) to rate level of integration, with level 1 indicating minimal collaboration and level 6 indicating full integration.[1] For the midpoint and final surveys, agencies were asked to fill out a rating tool created by BHACA staff based on the six-level framework. A copy of this tool can be found in Appendix D. At baseline, however, BHACA staff (including the evaluator then on contract) assigned each agency a level of 1 through 6 based on their assessment of level of integration from information provided in the baseline interviews. Therefore, although baseline ratings for level of integration are available, they are not truly comparable to midpoint and final ratings. Nevertheless, with this caveat, they are included here as a point of comparison.

Furthermore, at baseline, each agency was assigned only one overall level of integration. In contrast, more nuanced data was requested at the midpoint and final surveys. Agencies were asked to fill out separate tools for their overall agency services as well as for each distinct program or partnership providing integrated care to a subset of their population. Therefore, many agencies have more than one rating at midpoint and/or final survey. Since the care being provided through a specific program or partnership can vary substantially from that in another program or partnership or an agency's general services, these ratings

[1] Source: Heath, B., Wise Romero, P., & Reynolds, K. (2013). A standard framework for levels of integrated healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. Retrieved from http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

are more meaningful separately rather than as an average for the agency, and are therefore presented in that way.

Figures 6.1 to 6.8 show ratings for level of integration at baseline, midpoint, and final survey. Agencies have been included in these tables if they met two criteria: 1) they indicated that they were integrating care at final survey, and 2) they completed the rating tool based on CIHS' six levels at final survey.

Figures 6.1-6.8: Level of Integration – Baseline, Midpoint, Final

Legend:

Baseline

Midpoint

Final

Figure 6.1: Hospitals: Freestanding

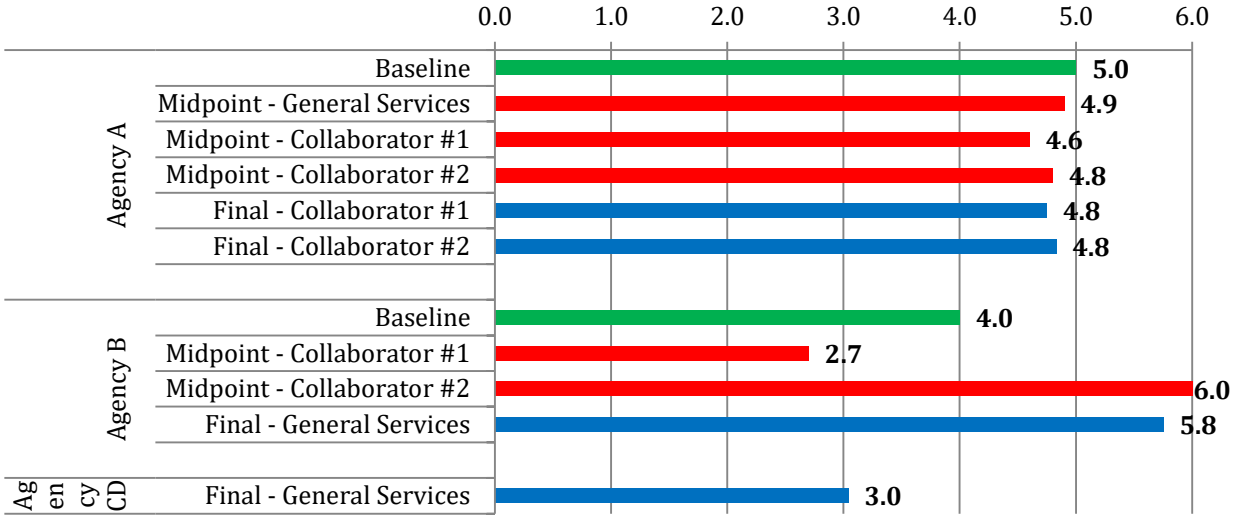


Figure 6.2: Hospitals: Department/Embedded

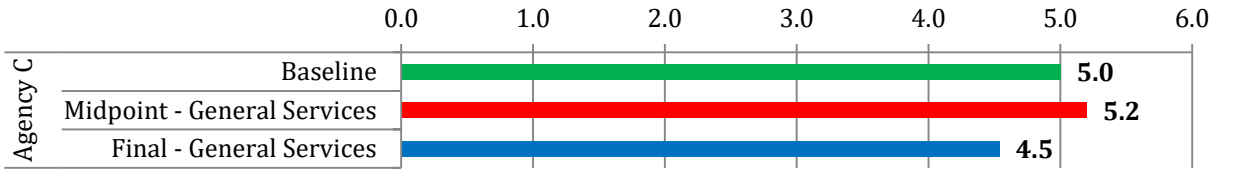


Figure 6.3: Primary Care & Mental Health Clinics

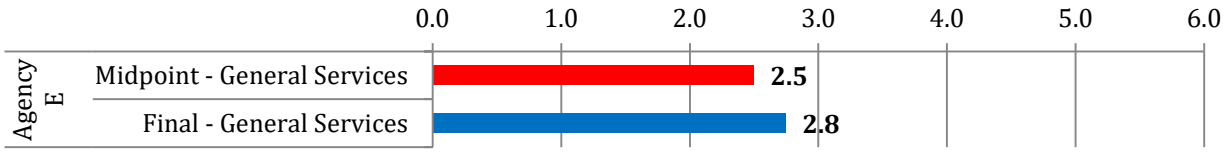


Figure 6.4: Federally Qualified Health Centers

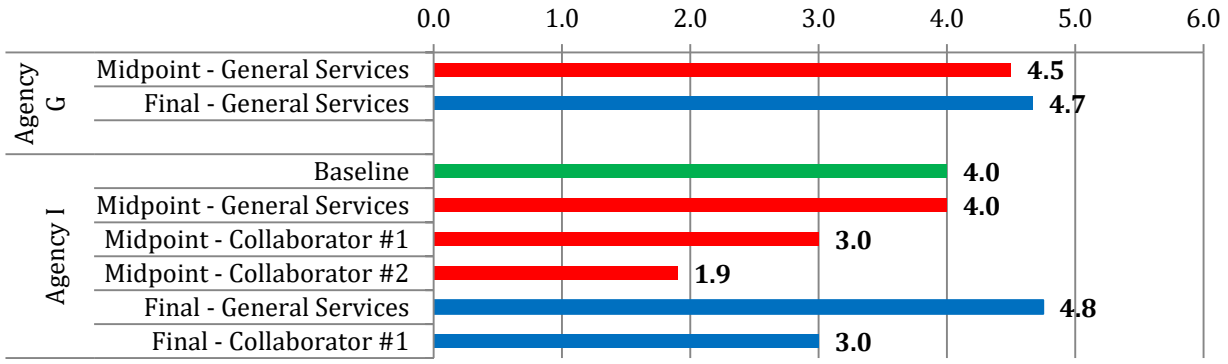


Figure 6.5: Mental Health Outpatient Facilities

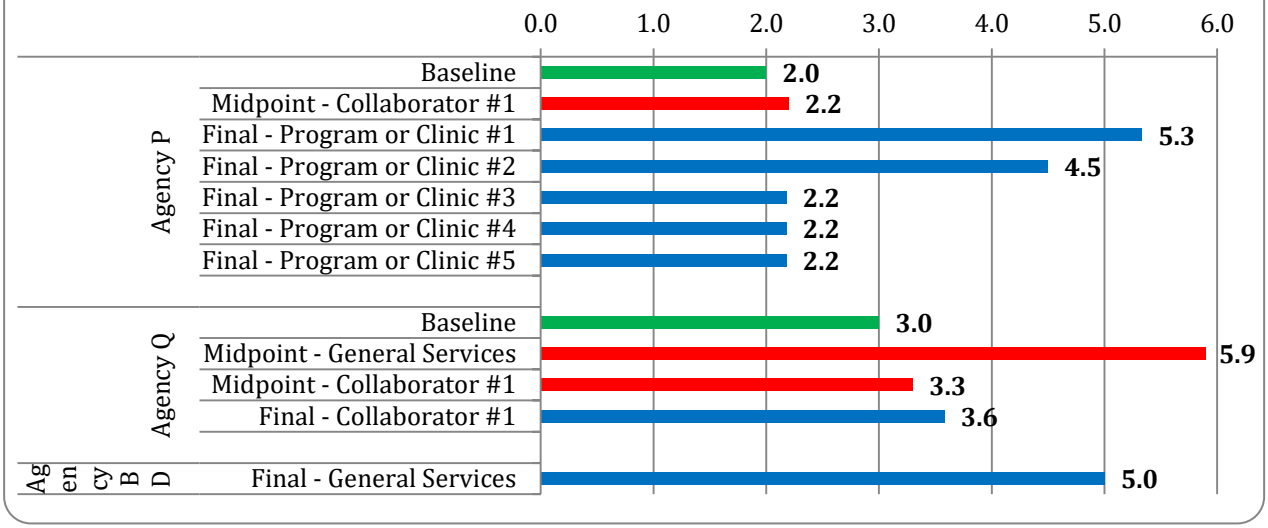


Figure 6.6: Subsance Use Multi-Level: Licensed Facilities

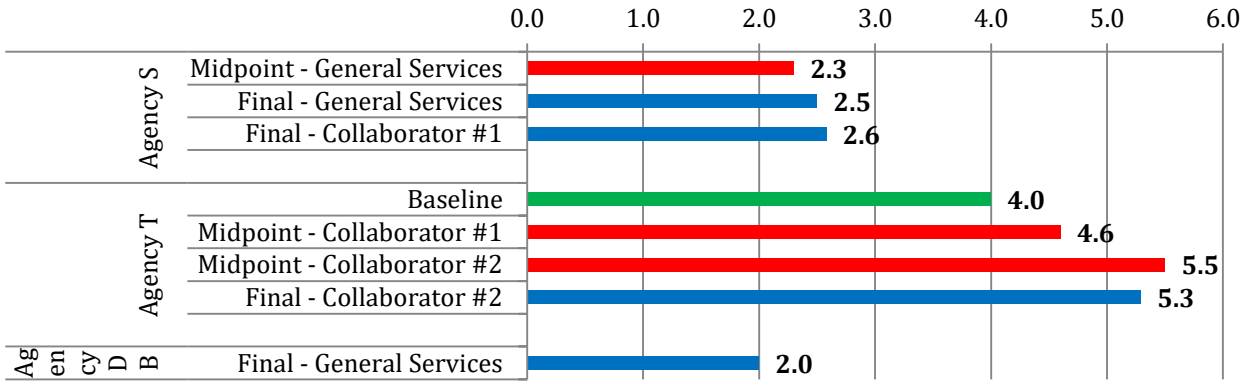


Figure 6.7: Substance Use Multi-Level: Unlicensed Facilities

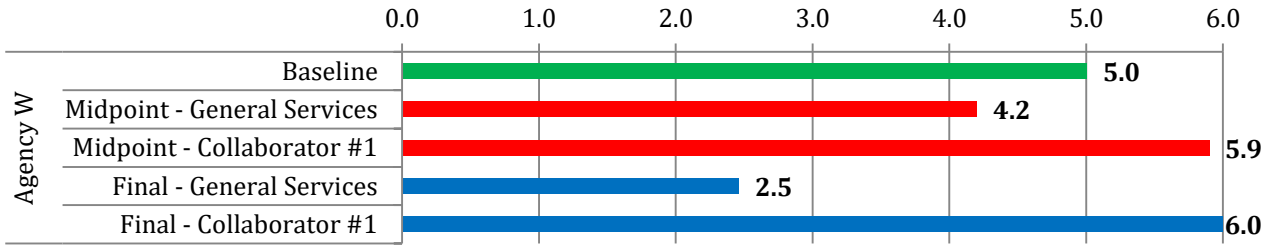


Figure 6.8: Substance Use Outpatient: Licensed Facilities

As is evident from the graphs, equivalent data for each time point is not available for each agency. In addition to the issues with the baseline data described above, some agencies were not members at baseline or midpoint. Also, some agencies provided data on different integration projects/programs/collaborators at midpoint vs. final survey. For example, Agency A provided information on its integration services with two collaborators (Collaborator #1 and Collaborator #2) at midpoint and final survey, but only provided information about integration across the entire agency (General Services) at midpoint. Agency P provided information about integration with one collaborator at midpoint; at final survey, the agency did not provide information about integration with that

collaborator, but did provide information about integration in five of its various programs/clinics. These types of discrepancies in the data are due partly to changes in various agencies' programs (e.g., programs or partnerships discontinued or begun) but also partly to differences in personnel filling out the survey, categorization of programs, and approach or attention given to the survey at midpoint vs. final survey.

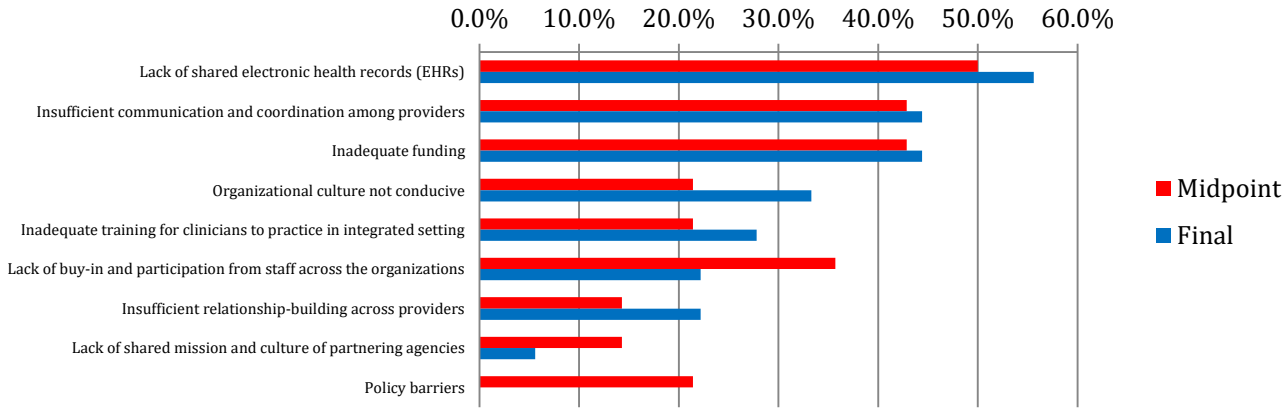
It should also be noted that the tool used to generate these ratings, although adapted from CIHS' well-respected framework, is subject to quite a bit of interpretation. Where one person might provide a rating of 4 for a particular category on the tool, another person might assign a 3 or a 5. Additionally, as agency staff learned more about what it truly meant to be integrated, they may have given lower ratings even when integration had stayed the same or improved; in other words, earlier ratings could be inaccurately high due to a lack of understanding of IHC. Also, the scores shown on the graphs are averages across all the categories for each tool filled out—so, for example, the average across all categories on the tool for a particular integration project at a particular agency. (For more information about how the scores were calculated, please see Appendix D.)

For all of these reasons, the scores provided in these graphs should be viewed more as informative indicators than as hard-and-fast numbers. Accordingly, a small numerical change, whether up or down, does not necessarily indicate a true change in service delivery. For example, a rating of, say, 4.2 at midpoint could be interpreted as similar to a rating of, say, 3.8 or 4.5 at final survey. However, a change of close to a full integer or more could be interpreted as indicating a more substantial change in services.

With all this in mind, one can see that, in general, agencies either increased or stayed at a similar level of integration from baseline to midpoint to final survey. Implementing, advancing, and sustaining integrated health care services can be quite challenging—particularly for behavioral health care agencies, as mentioned above. Given the challenges in implementing IHC, and the long-term nature of advancing and sustaining it, the overall indication that agencies either maintained or advanced their level of integration is a positive finding.

With regard to challenges, agencies were asked to identify the challenges that they had encountered in implementing integrated care. A summary of their responses can be seen in Figure 7 below. Similar challenges were identified at midpoint and final survey. (Note that since the number of respondents to this question was not high—14 at midpoint and 18 at final survey—a small or medium percentage change does not indicate a major change in responses.) Notably, two of the top three areas identified as challenges—lack of shared electronic health records and inadequate funding—relate to other BHACA focus areas. This reinforces the interrelatedness of the BHACA focus areas and the importance of advancement on multiple fronts in order to advance integrated health care.

Figure 7: Challenges in Implementing IHC



Qualitative Input on Changes in IHC

While the overall trend towards increased levels of IHC is encouraging, it is also important to remember that agencies' advancement in IHC may not always be reflected by a change in "score." For one thing, agencies' scores for level of IHC are subject to nuanced interpretation, as already discussed. Also, given the challenges in implementing IHC, progress may be incremental. Agencies may make small changes that aren't immediately reflected in a changed score, but that over time will add up to significant advancement.

For these reasons, it's also important to consider agencies' qualitative input regarding changes in their IHC, whether or not reflected by a change in score. As will be shown in Figures 14 to 17 on pages 42 to 44, substantial percentages of agencies completing the final survey indicated that their perspectives and activities on IHC had changed during BHACA, and that BHACA had influenced those changes.

Various comments from midpoint and final surveys illustrate how BHACA has influenced agencies in the area of integrated health care. The following are a few examples.

- Creating "an increased focus on training for providers."
- "BHACA has helped with some of the framework and putting IHC to the forefront of project planning."
- "Broadened [agency's] perspective regarding integrated healthcare services. Examples and applications of IHC have been shared and this creates resources as [agency] moves further into IHC."
- "Understanding how IHC differs from co-location and collaboration; development of relationships."
- "Helped us in determining what factors were most important for our agency when choosing a partner. Framework to guide decision making."

One example of BHACA's influence is that of a federally qualified health center that had had co-located mental health and primary care services for a number of years, but these services were not truly integrated. With the support of BHACA, the agency has progressed toward much more integrated services; final survey data indicate that the agency is now at close to level 5 integration. The organization credits BHACA with helping them to "increase knowledge of practical implementation of IHC" and "provid[ing] education and guidance in helping the organization implement IHC." The agency has indicated that, through one of BHACA's educational events ("Behavioral Health Screening in Primary Care Settings," September 2014), they were able to connect with an expert (a presenter at the event) whom they were subsequently able to shadow and utilize as a consultant to help them adopt a more integrated model of care. Recently, BHACA staff learned that this organization's lead behavioral health staff person, who has been instrumental in spearheading their integration efforts, is moving to another FQHC, where he similarly plans to implement an integrated model of care with the continued support of the consultant whom he initially met through BHACA.

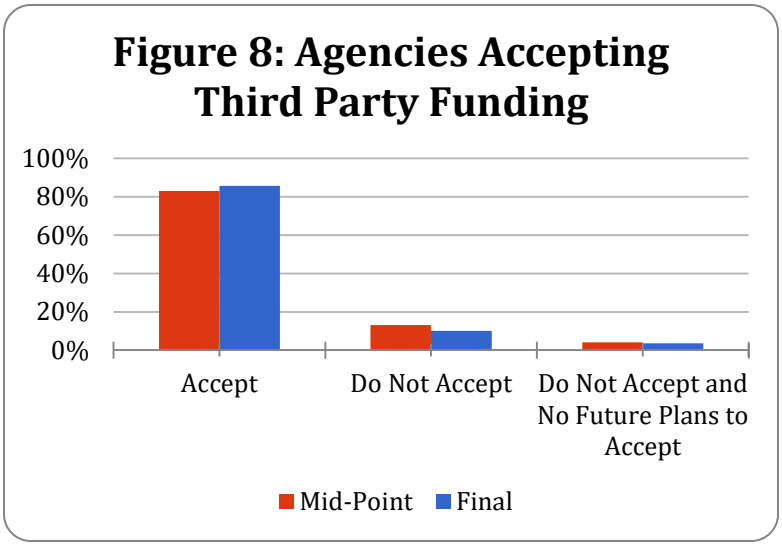
It is also worth noting that even agencies that are not currently integrating care may have been influenced by BHACA – whether by increasing their awareness of IHC or helping them move forward with planning efforts. A few comments from the final surveys illustrate this point. One agency stated that BHACA "brought [the] issue into our consciousness," perhaps planting a seed for future germination. Another agency, which has a partnership planned for spring 2017, credits BHACA with "stressing the importance and offering a path." Yet another agency noted the following:

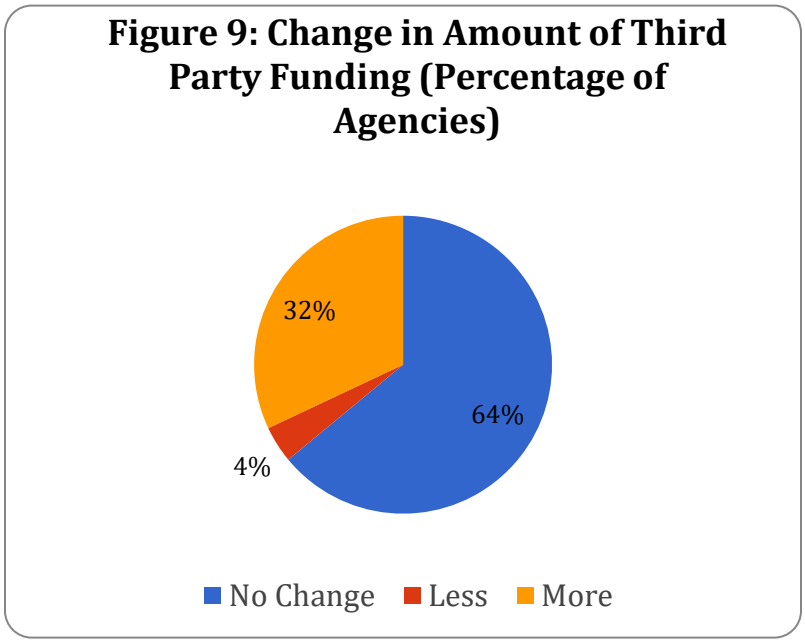
> *BHACA has contributed to [our] perspective in integrated health care by helping us better understand the benefits of IHC and the feasibility of participating in such a partnership. We are now in a planning stage which is a step forward from where we were before benefitting from BHACA. In terms of activities BHACA has provided valuable education on IHC that has been used to help potential partners understand the benefits of engaging in IHC, including improved outcomes for patients/clients, as well as, the option of integration at a level short of full integration that may allow for needed flexibility.*

As is evident throughout this report, NBHP agencies are quite diverse. This is no less the case in terms of IHC. Some NBHP agencies are not interested in integrating care at this time, but BHACA may have increased their awareness of it. Others have been assisted in their planning efforts. Others have made strides in advancing their level of IHC. Still others were operating at a high level of IHC to begin with, and have continued to do so. While BHACA has impacted these agencies in different ways and to different extents, the overall impact on IHC in the greater Houston behavioral health community appears to be positive with increased understanding of IHC, various planning efforts in progress, and movement towards more advanced levels of IHC.

Third Party Funding

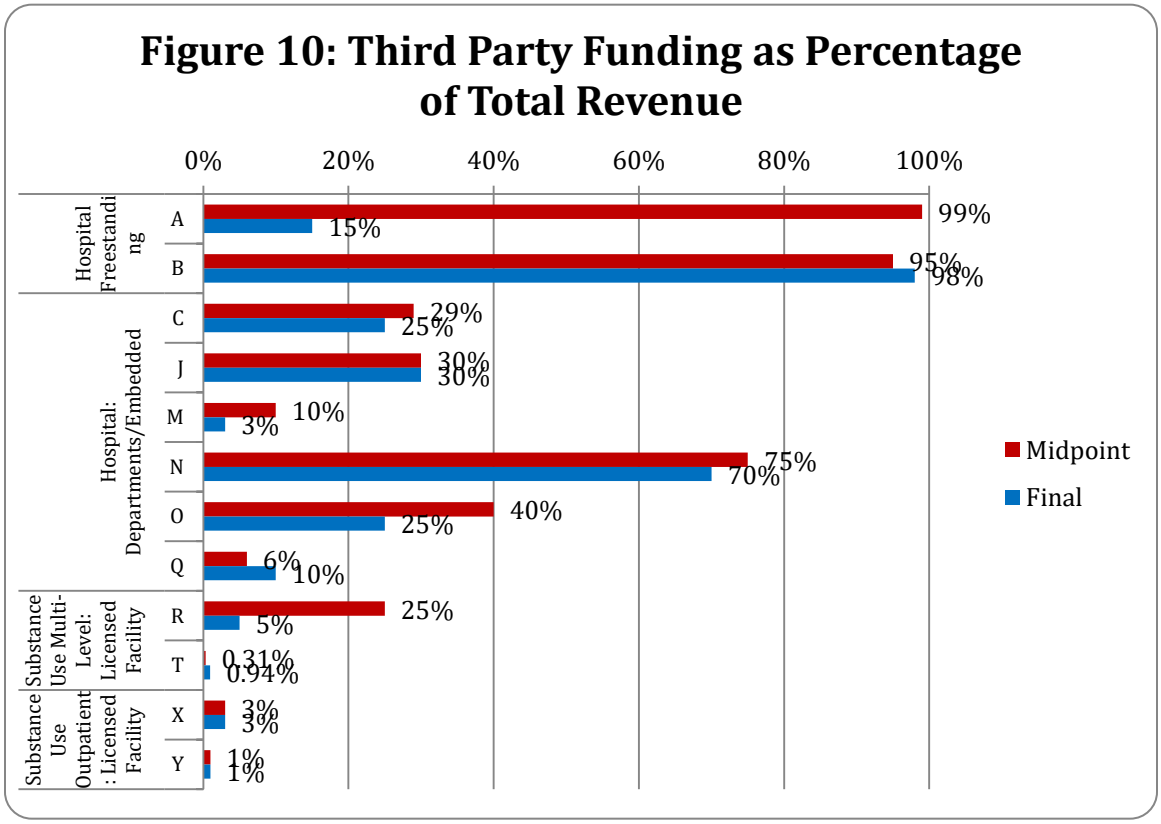
Our data on NBHP members' receipt of funds from third party payers, for the most part shows change in the desired direction. Beginning with the baseline survey, 19 of the 23 responding members reported that they were Medicare and/or Medicaid certified. While this seems like a very positive beginning point, we have been reminded by member agency billing staff that reviewed this data that being certified is not the same thing as actually filing claims and receiving reimbursements. Many agencies have received Medicare and Medicaid certification numbers but never actively pursued that funding stream. When we conducted the midpoint and final surveys, we asked the agencies if they "accepted" third party funding—the change in wording taking them from merely an inactive designation to active participant/recipient. Figure 8 summarizes the answers to that question from the midpoint and final surveys. The data shows that there was virtually almost no change in the reports of which agencies accepted third party funding and which did not.





And yet in Figure 9, taking the question one step further, one can see that, while the majority of respondents felt that they had seen no change in the **amount** of third party funding they were receiving, 32% did. In other words, while the simple number of agencies accepting funds from this source moved very slightly upwards (Figure 8), the actual amount **received** from third party funders did increase somewhat (Figure 9).

Then we come to Figure 10 that paints a very confusing picture. Of the 13 NBHP agencies that provided answers at both time points, only 3 reported third party payments as a major funding source (over 50%) at least one of those two times. More puzzling for our purposes, 6 of the agencies reported a drop in third party funding as a percentage of their overall revenue. Obviously, we find these contradictory responses troubling. It would seem that any service provider, at any point in time, should be very aware of its payer mix as it is something they are constantly assessing and working on. In the upcoming months, we intend to revisit this question and see if we can at least establish valid baseline estimates and then begin to build on those.



There are several plausible explanations for these inconsistent differences, but in general they could point to real change or come under the category of bad data. In the first case, our billing staff reviewers reminded us that, because Medicare and Medicaid reimbursement rates are lower than private insurance rates, a large increase in public third party reimbursements (as opposed to other forms of reimbursement) could possibly lead to a smaller impact on the percentage of total funding that third party represents. As for the bad data reasoning, we know we had several flaws in our data collection. First we don't know if the person who completed the midpoint survey was the same person who responded to the final one. (We did inquire and found out that in the most extreme case of Agency A, it was not the same person and that the CEO was the respondent for the final questionnaire.) We also failed to provide the agencies with the midpoint answers. Even if the same person completed the survey, we would be surprised if they could tell us the answer they gave us 18 months ago.

To gain a little better perspective on these "inconsistent" stories, we created a table of the agencies that reported percentages that third party funding made up of their total revenue at both time periods and compared it with the survey question that asked whether or not their third party revenue had gone up or down and by how much. As you can see, the two agencies that reported their income from third party sources had gone up (in the comments section) also provided percentages that went down, and the two that stated they had no change actually did report change (one significant, 25% down to 5%).

Table 1: Comparison of Conflicting Answers on the Question of Change in Percentage of Revenue from Third Party Sources

Deidentifier	What percentage of your agency's overall revenue comes from third party funding (combined Medicare, Private and Medicaid)? (Midpoint)	Final	Comments
Hospital: Freestanding			
Agency A	99%	15%	11-25% more
Agency B	95%	98%	
Hospital: Department/Embedded			
Agency C	25%	25%	
Agency D	85% to 90%	Does not know	No change
Mental Health Outpatient			
Agency J	about 30%	30%	
Agency M	10%	3%	No change
Agency N	75%	70%	
Agency O	40%	25%	26-50% more
Agency Q	6% but growing	10%	
Substance Use Multi-Level: Licensed Facility			
Agency R	Not inclusively grants and donations; meaning only between insurance and other contracts it is about 25%	5%	No change
Agency T	< 31%	94%	
Substance Use Outpatient: Licensed Facility			
Agency X	2% - 3%	3%	
Agency Y	Less than 1%	Less than 1%	

To summarize, in light of these data challenges, we would suggest that the data in Figures 8 and 9 are reasonable and meaningful, and we can conclude that some increase in third party funding revenues is likely to have occurred for a number of our agencies, but that increase is by no means an across the board commonality. For agencies that focused on this particular issue and had staff that made the reduction of claims denials a priority, they were absolutely successful in reaching that goal. Most important, as related in the Third party events section above, the real value in this component of BHACA rests in the well-received billing education program/curriculum we developed and will be able to continually update and provide to the state's behavioral health community.

Finally, it is telling to relay the impact of this education on one particular member. This faith-based agency joined NBHP at the beginning of the BHACA project, and the Executive Director actually commented that he enjoyed participating in the organization but would

not be much involved in BHACA since their work was totally supported by private funding and they, by principle, would never accept public support. At the project midpoint, the Executive Director noted, with pride, they had almost completed the space in their facility for Harris Health System to place a clinic. As the BHACA project winds down, the agency is in the final stages of signing a contract with the county Jail Diversion Project and will accept state funding for provision of services to the clients that come from that program. When the NBHP Executive Director commented to the agency ED that this sounded like a complete turnaround in philosophy for their agency, the ED laughed and said, "Are you kidding? This is huge for us. Because of what we have learned in BHACA, we have completely changed our stance. We even had to change our bylaws!"

Certified EHR

When BHACA began, 20 of the 23 agencies responding to the question on the baseline survey reported having a certified EHR system. Upon review of these responses, we discovered that 11 of the 20 named systems ARE NOT certified EHRs (and we very specifically asked if they were sure it was a certified EHR). Thus from the start, we realized that not only was there a need to assist providers in obtaining EHRs, but there was an initial need to educate them as to just exactly what they had, and why it did not provide what a certified system did.

In collecting data for this final evaluation report, we asked every current member about their status in this area. So Table 2 below provides an up to date overview of the status of NBHP members on EHR acquisition divided into 8 categories and arranged roughly in a highest to lowest level of care order separating mental health providers from substance abuse (recognizing that many of our members provide both but approach their services primarily from one or the other).

As can be seen in the table, 2 of the 3 psychiatric hospitals have EHRs, as do both of the large med-surg hospital systems (most since very early on in the ACA adoption process). Only one of the primary care/mental health clinics has a certified EHR, and it is the one that is part of a hospital/medical school—the other two are stand-alone nonprofits. For the 5 FQHC members, all 5 report having systems. It is important to note that we found that many of the clinics that contract with medical schools for their doctors have been allowed to access the system used by the school. In short, what we can see here is the huge difference that being included in the list of "eligible providers" chosen by the federal government clearly made in who could access an EHR and who could not (most behavioral health agencies NOT having an eligible MD on staff to qualify). Even with the federal financial incentives, the purchase of systems is enormous and thus, with few exceptions, only large health systems providers have the level of funds needed for this kind of expenditure.

Once we get past these first hospital and hospital-related or federally supported health clinic categories, the number of agencies using certified EHR systems falls off sharply. While 6 of the 9 providers in the category Mental Health Outpatient Clinics report having a system, when the array of agencies is analyzed, it is clear the same pattern is at work. Of

those using systems, one entity is our local mental health authority, one is an agency that received funds as an IHC federal grant partner, two others are part of a national nonprofit and received their system through that larger entity, and one is very well-endowed provider whose budget was able to support the purchase. Only one of these agencies is a small, community-based organization that managed to purchase a system on their own, and the process involved a huge leap of faith by that agency's board. Conversely, of the remaining three agencies in this category who are using another type of data management system, two are among the largest of community mental health nonprofits and thus their status (and comments regarding the impossibility of finding the funds for purchase) underscore the enormity of the financial resources it takes to purchase, receive training, implement, and maintain an EHR.

The picture is most dismal for substance abuse providers. As can be seen below, of the 11 NBHP substance abuse provider members, only two have certified EHRs, and those two are significantly larger than any of the other providers in this arena. There are two other notable findings for these providers. The first is that the system Clinical Management for Behavioral Health Services (CMBHS) was reported by several of the providers as their certified EHR in the baseline study. CMBHS was developed in 2009 by the Texas Department of State Health Services (DSHS) as a required web-based clinical record-keeping system for state-contracted community mental health and substance abuse providers. While referred to as an electronic health record on their website, DSHS has made it clear that they have no intention of modifying it in the future to meet EHR certification guidelines. NBHP substance abuse provider members have shared their frustration with the system and the enormous amount of time it takes to enter the required data files. Thus, these providers are not only limited by financial resources from considering EHR adoption but equally if not more off-put by the notion of having to add another data collection effort to their staffs' workloads.

Table 2: NBHP Member Agencies' Adoption of Certified Electronic Health Record Systems at Baseline, Midpoint, and Final Evaluations

Blue = Certified EHR Red = Respondent's original answer naming a system that is not a certified EHR ——— = Not a member at that time None = Not using an EHR or data management system

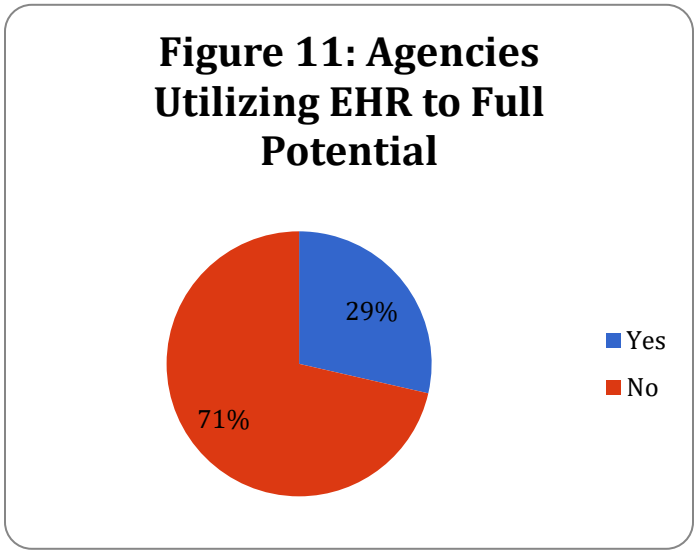
Category	Deidentifier	Baseline EHR System	Midpoint Survey EHR System	Final Survey EHR System
Hospital: Freestanding	Agency A	**Allscripts (Eclipsys) Sunrise Clinical Manager (Siemens) Cerner INVISION (ADT & Billing)**	**Allscripts (Eclipsys) Sunrise Clinical Manager (Siemens) Cerner INVISION (ADT & Billing)**	**Allscripts (Eclipsys) Sunrise Clinical Manager (Siemens) Cerner INVISION (ADT & Billing)**
	Agency B	**Medsphere - Hospital Medisoft - Clinic**	**OpenVista CareVue**	**OpenVista CareVue**

	Agency CD	_____	_____	Midas and AS400 for data management
Hospital: Department/Embedded	Agency C	**EPIC**	**EPIC**	**EPIC**
	Agency D	**Cerner Care4**	**Cerner Care4**	**Cerner Care4**
Primary Care & Mental Health Clinic	Agency AC	_____	_____	**Practice Suite**
	Agency E	_____	None	Efforts to Outcomes
	Agency F	Evolve	Evolve	Evolve
FQHC	Agency G	_____	**EPIC**	**EPIC**
	Agency AD	**Centricity**	**EPIC**	**EPIC**
	Agency H	_____	**Greenway (SuccessEHS)**	**Greenway (SuccessEHS)**
	Agency I	**Centricity**	**Centricity**	**Centricity**
	Agency AE	**Sevocity**	**EPIC**	**EPIC**
Mental Health Outpatient	Agency J	Social Solutions - Efforts to Outcomes	Social Solutions - Efforts to Outcomes	Social Solutions - Efforts to Outcomes
	Agency K	**Psychconsult Askesis**	**Psychconsult Askesis**	**Psychconsult Askesis**
	Agency BD	_____	_____	**Valant Medical Solutions**
	Agency L	dataTraQ	dataTraQ	dataTraQ
	Agency M	Kaleidacare EMR	Kaleidacare EMR	Kaleidacare EMR
	Agency N	**Valant Medical Solutions**	**Valant Medical Solutions**	**Valant Medical Solutions**
	Agency O	**Credible Behavioral Health System**	**Credible Behavioral Health System**	**Credible Behavioral Health System**
	Agency P	Topaz now, and constructing new system with Cerner	**Cerner**	**Cerner**
	Agency Q	Compass	**Continuum**	**Continuum**

Substance Use Multi-Level: Licensed Facility	Agency AF	Clinical Management for Behavioral Health Services (CMBHS)*	CMBHS	CMBHS
	Agency R	**Qualifacts Carelogic**	**Qualifacts Carelogic**	**Qualifacts Carelogic**
	Agency S	_____	None	None
	Agency T	CMBHS	CMBHS	CMBHS
	Agency DB	_____	_____	**Welligent**
	Agency DD	CMBHS	CMBHS	CMBHS
	Agency U	Client Management System	Client Management System	Client Management System
Substance Use Multi-Level: Unlicensed Facility	Agency V	None	None	Client Track
	Agency W	Homeless Management Information System (HMIS)	HMIS	HMIS
Substance Use Outpatient: Licensed Facility	Agency X	Paradox database and CMBHS	Paradox database and CMBHS	In process of choosing new data management system
	Agency Y	CMBHS	CMBHS	CMBHS

***Clinical Management for Behavioral Health Services (CMBHS and pronounced Columbus) is the data management system required by the state to be used by all providers receiving state funds.**

Finally, even among those providers who have certified EHRs, we discovered that there is still work to be done. Table 11 provides the summary of responses we got to the question of whether or not agencies were using their EHR to its full potential, with almost three quarters saying they were not. This finding was underscored in the responses we received when we asked how BHACA had contributed to their



perspective and activity regarding an EHR. Among those member agencies that are using a system, several made comments about usage. "The BHACA Initiative helped us strengthen the perspective that we need to use more of our EHR capabilities, and we are moving in that direction." The most insightful comment we received spoke to a more in-depth understanding of, not just the role of the EHR, but the connectedness of all the BHACA focus areas. "BHACA was influential in our thinking about how to integrate outcome measurements into our EHR. Billing classes helped inform our billing process in our EHR system."

Outcome-Based Evaluation

In the baseline interviews, NBHP members were asked how prepared they felt they were to conduct outcome-based evaluations. Of the 22 respondents who answered the question, 2 stated they felt ready, 5 said they "felt capable," 6 considered themselves in development, and 9 stated that they had not started working on this area. When they were asked if they would like training in the area, 16 of the 22 respondents replied that they would. One would assume that the 16 who expressed interest in receiving training would be the agencies that also answered they were in development or had not started work in OBE. This is the case for 12 of the agencies. Of the 4 less prepared agencies that did not indicate training interest, 3 were in development and one had not started. Of the 4 better-prepared agencies that replied yes to receiving training, three said they felt capable and one stated they were ready. While we can conclude that, in general the agencies that were interested in training were on the lower end of progress in developing an OBE, the remaining agencies interested in receiving assistance were more likely to be on the high end of preparation.

On the midpoint survey, we asked agencies to tell us what specific client data they collected. We repeated this question on the quality measurement survey that will be described below. As you can see from the summary data illustrated in Figure 12, responses on the midpoint survey indicate that a high percentage of agencies were collecting data for all six data categories about which we asked. It is not surprising that the numbers are high for four of these variables—number of clients screened, number of clients served, number of visits per client, and type of treatment client receives—because these are the traditional evaluation "number counts" that are now considered inadequate because these variables say nothing about quality of care and/or outcomes. Except for number of clients screened, these data collection variables virtually stayed the same. There is no problem in collecting this data; it just doesn't go far enough in enabling a reviewer to make any judgment regarding the agency's success in providing care that leads to improved health.

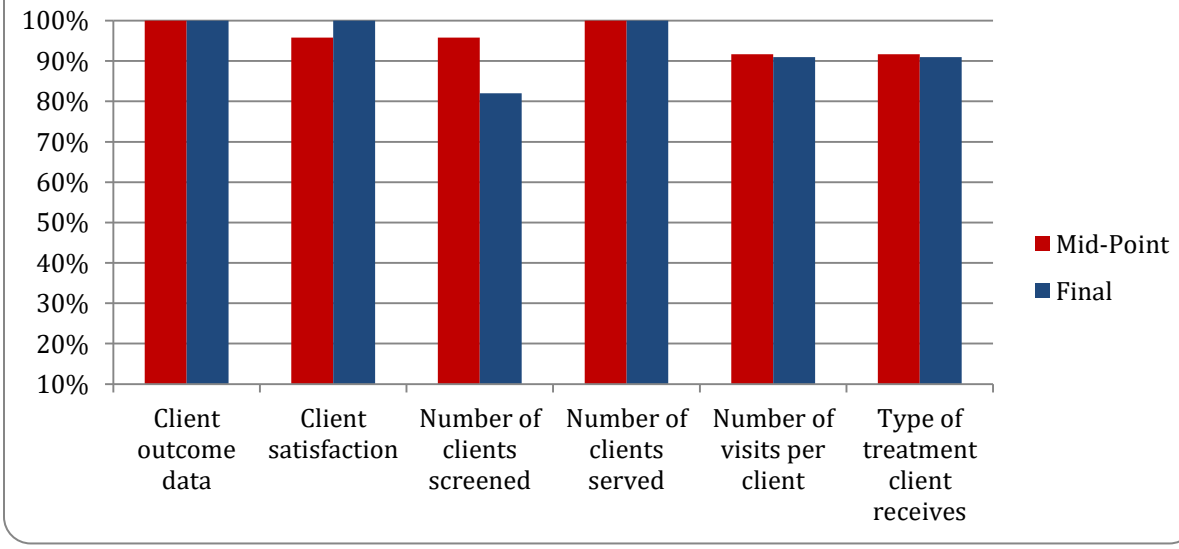
The only bar that shows an increase is client satisfaction. We view this increase, although slight, to be a positive sign because, even though a client's happiness or lack thereof with their care is not a health outcome, health care reform includes the participation of the client in their health care decisions so their satisfaction with the care they receive is important in the overall context of the ACA vision.

It is the first bar, measurement of client outcomes that is of most importance as far as BHACA and health care reform are concerned. The fact that 100% of respondents reported

collecting client outcomes at both time points suggests that NBHP agencies had already attained the desired goal of collecting client outcome data and that identical results can be interpreted as unequivocal evidence of no change. We would argue, however, that this is a case in which the simple tally falls far from telling the entire story. Instead, we believe there has been change, maybe not in the simple yes or no to the question of whether outcome measures were being used, but in the more in-depth question of what measures are now being used, and whether the agencies made changes in which instruments they use based on the additional information they have received through BHACA on validity, reliability, usage by other members, etc.

As will be discussed below, the issue of quality measurement has become a huge focus for all sectors of the health care industry, from applied and academic researchers, to government agencies, to insurance companies. Over the last half of the BHACA project, staff has focused significant time on assisting NBHP members in their understanding of and selection among the enormous array of quality measurement instruments. One agency staff member said "the outcomes workshops have helped fine tune our outcomes process including logic model training and workshops on replacing the GAF." Thus while the two bars may appear identical, we would argue that within those two symbols, there is major change and are significant differences. In addition to increased knowledge, we have also heard from members that BHACA has contributed to their commitment to collecting and reviewing outcome data. Another agency member stated, "We are currently measuring outcomes for 1 of our 7 units. My goal in 2017 is to have outcome measures for every unit."

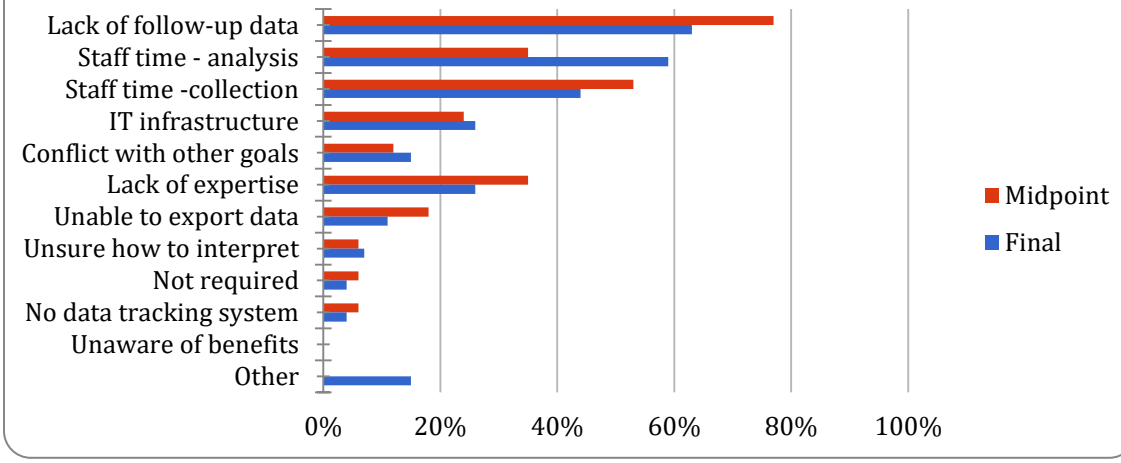
Figure 12: Types of Evalution Data Collected



In our OBE trainings with Dr. Watt, participants spent a great deal of discussion time talking about their understanding of the importance of good outcome-based evaluation measurement and their commitment to performing the best evaluations they could. However, the realities they confront when attempting to conduct high quality evaluations leave them frustrated and less than satisfied with the results that they are able to produce.

Figure 13 provides the responses we received at both time points when we asked NBHP members what the barriers were when measuring outcomes. The good news is that, for 6 of the 11 barriers cited, the situation has improved. The greatest improvements are in the ability to collect follow-up data, staff time spent on data collection, and lack of expertise. The first two areas would suggest that agencies are getting better at tracking clients over time and that staff is doing a better job in performing evaluation tasks. (It is then not surprising that analysis of data by staff has become a greater barrier if more data is being collected.) The last area, decrease in lack of expertise, is an indication that since BHACA has started, agencies are feeling more confident about their abilities to measure outcomes.

Figure 13: Current Barriers to Outcome Measurement



To reiterate, the outcome-based evaluation data is not straightforward and the interpretations we have proposed can certainly be questioned. Our final argument would be that the data we collected on change in perspectives and activity and the impact of BHACA on those two areas (discussed at the beginning of the Conclusions section) would support our final judgment that BHACA did have a positive impact on NBHP member agency outcome-based evaluation efforts.

The evaluation process aside, the whole issue of measuring client outcomes was a major challenge in itself due to the number of measures out there including a lack of clarity on which were evidenced-based/best practice, using ones required vs. those that could be more meaningful to the agency, and lack of information on their validity and reliability. It should also be noted that outcome measurement grew increasingly more important during the life of BHACA, in large part because the federal government, through several entities, began to announce specific "required" measurements for certain diagnoses. An outcry from the health community quickly followed which argued that measurements were being chosen without the input of MDs and other professionals who actually performed this measurement and, thus, chosen instruments were not always those considered best practice. When we contacted the medical expert authors of these academic journal articles and asked if they could provide us with data on the behavioral health side, they graciously

replied noting that, to their knowledge, no one was working on that piece but it was their opinion that, based on the dismal situation for physical health, it could only be far worse for behavioral health.

Due to these serious and growing concerns, significant attention was given to this particular component due to the lack of understanding/clarity we were hearing from members, the new push toward quality of care as a reimbursement criterion, and the rapidly changing and confusing messages coming down from regulating bodies. In response we worked with a faculty member of the University of Texas School of Public Health, Fleming Center for Healthcare Management and one of her graduate students. The outcome of that partnership was a limited-time, focused applied research project with the goal of better understanding and evaluating the quality performance measures collected by our members through the following three objectives. The first was to analyze commonalities between the quality measures currently collected by member organizations and those commonly used in the industry. The second was to categorize measures by purpose, e.g., required reporting, inform care or treatment, assess performance, patient progress, etc. Finally, the third was to ascertain best practices from a literature review and guidance from NBHP member organizations. (Note: Please see Appendix E for a more detailed discussion of the challenges with quality measures.) A particular focus of the project was providing the members with resource materials regarding the current state of behavioral health measures, programs or institutions tracking and participating in Pay for Performance (P4P) or Pay for Reporting (P4R), as well as measure standardization strategies. The findings of this quality project will be utilized to support member collaboration, inform future policy, benchmark current practices, and facilitate the implementation of new quality performance measures, as needed.

Members now have access to a behavioral health measure dictionary that outlines the most frequently utilized and best practices outcome measures and screening tools. Once agencies reach the capacity for new measure implementation or change, they can reference this dictionary to identify potential new measures and their uses. Members will also have access to an Excel document that shows which behavioral health measures are being tracked in the P4P or P4R programs. This document will be a beneficial reference for agencies struggling with reporting requirements and new reimbursement regulations. Members can also access materials regarding measure standardization strategies within communities. The Robert Woods Johnson Foundation has compiled this information from their work with communities around the nation. As outcome-based evaluation is a very significant component of an organization's operations, BHACA hopes to support the members in their efforts to comply with recent measure reporting regulations.

CONCLUSIONS

SURVEY RESULTS ON PROJECT IMPACT

At the end of three years and 78 events, what did all this work mean to the professionals for whom it was developed? Our event evaluations convince us that the trainings and educational events themselves were unquestionably of value to our participants. But at the end of the day, did all this effort make a difference in the thinking and the actions of those who were there? To answer these "where the rubber hits the road" bottom line questions, we concluded each of the four survey sections with a series of interrelated questions:

1. Since you and your staff started participating in the BHACA Initiative, has your PERSPECTIVE on the role of *[IHC, third party funding, EHRs, outcome-based evaluation]* in your agency operation changed?

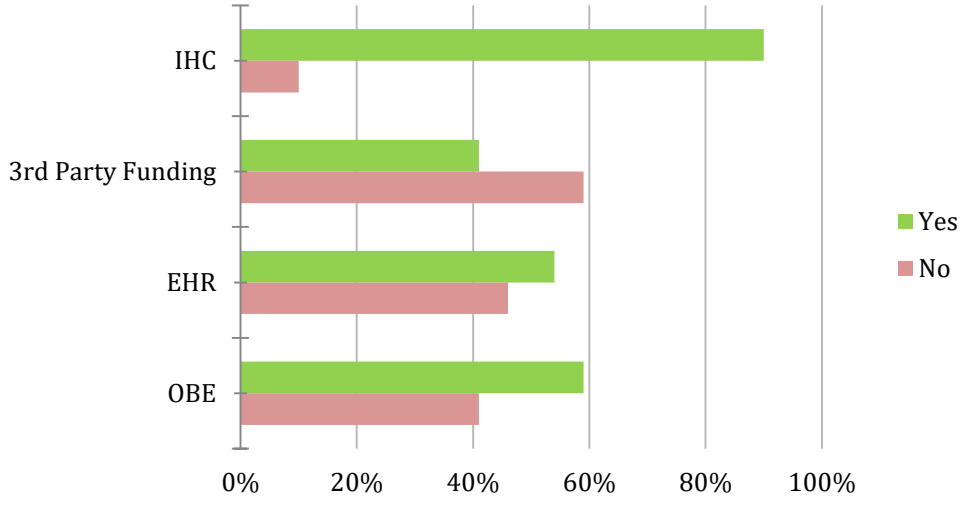
    1a. If yes, BHACA has/has not impacted our perspective.

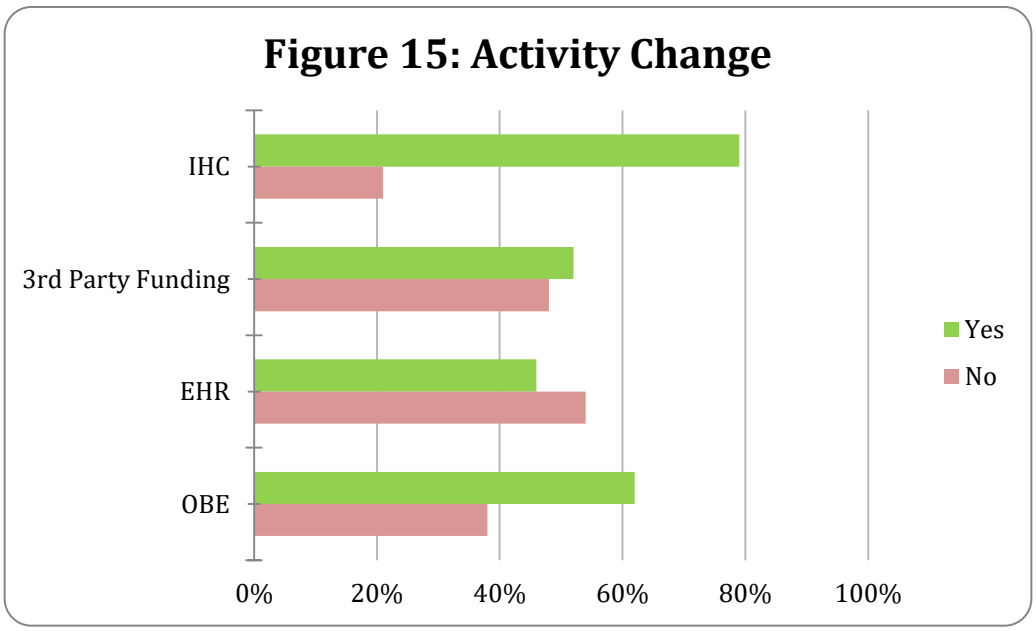
2. Since you and your staff started participating in the BHACA Initiative, has the *[IHC, third party funding, EHRs, outcome-based evaluation]* ACTIVITY at your agency changed?

    2a. If yes, BHACA has/has not impacted our activity.

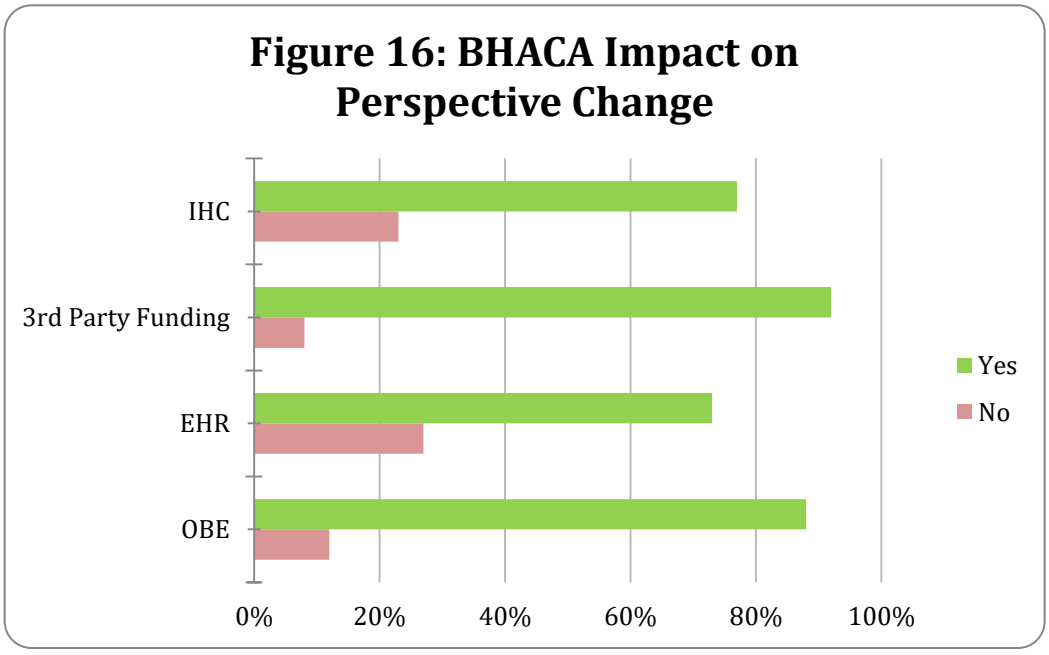
Figure 14 summarizes the findings for each area on change in perspective. As can be seen, with the exception of third party funding, most respondents reported change in perspective in each area with the largest number of respondents reporting change in IHC (90%). Similarly, the bars in Figure 15 show corresponding changes in activity. Although not quite as high as perspective results, the activity change goes from a low of 46% for EHR to a high of 79% for IHC. It is also interesting that for third party funding where we had the least change in perspective, the responses flip on the question of activity where the respondents answering "yes" break the 50% mark and thus outnumber the "nos." This is a case in which we believe that we can safely say that the classes offered in billing may not have changed their views on third party funding but they may very well have changed their operations.

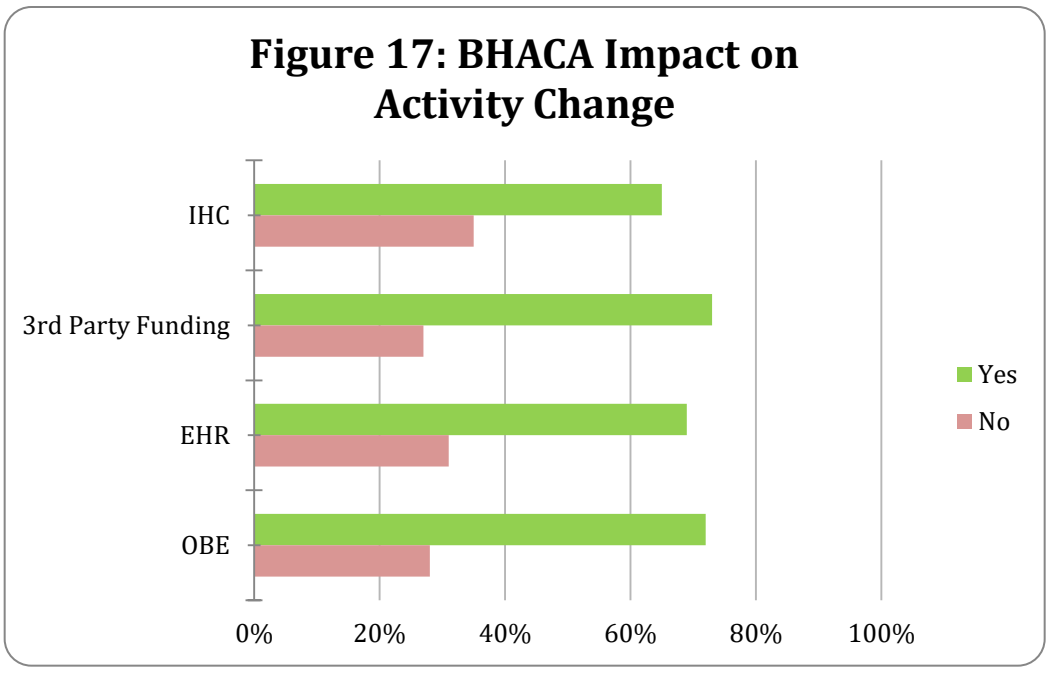
Figure 14: Perspective Change





We then asked if BHACA had contributed to those changes. Figures 16 and 17 show the results for perspective and activity respectively. Respondents overwhelmingly indicated that BHACA had impacted their perspectives and activities.





While the data shown in these graphs provide evidence of BHACA's impact, a few testimonials from NBHP agencies help paint a fuller picture of this impact.

- *Jewish Family Service has been significantly impacted by the services of the BHACA Initiative. Since late 2013, 12 staff members in our agency have participated in nearly 30 BHACA events, increasing the knowledge base in every department. We saw the most significant impact in our billing services. The knowledge we gained from BHACA's monthly classes decreased the time spent on billing tasks, increased the confidence and accuracy of our billing staff, and strongly influenced the 25% increase our agency saw in third party revenue streams. The classes on preparing for the ICD-10 transition helped us to achieve uninterrupted billing following the October 2015 rollover, with no payment denials. We also found the outcomes classes to be particularly helpful to us in developing a more robust program evaluation system. Specifically, we received timely instruction and assistance in reviewing our program logic models, adding logic models for new programs, tightening our outcomes measurements, and selecting outcome instruments. The networking opportunities have been crucial in helping us refine our processes, communicate innovative ideas, and share best practices. As the Director of Operations, I cannot overstate the value of the BHACA Initiative to our agency, and am grateful for the opportunities it provided to help us improve performance, service delivery, and agency management.*

  ~Stephanie Tucker, MS, LMSW, Director of Operations, Jewish Family Service

- *BHACA has filled an important void for us by educating our executive and clinical staff on the elements that need to be in place to navigate the evolving healthcare industry. The BHACA team has provided insight into, training for, and validation of our efforts to roll out and implement an electronic health record, a system for measuring outcomes, and a fee assistance program that is compatible with the premium subsidies for coverage purchased on Healthcare.gov.*

  ~Steve Duson, Executive Director, Interface-Samaritan Counseling Centers

- *I consider the Network of Behavioral Health Providers a key partner to Catholic Charities' Counseling Services programs. In recent years, the Network's BHACA project has been especially helpful as a highly valued source of credible information and consultation services. BHACA has been able to provide support on a wide scope of topics pertinent to providers, like myself, seeking to understand current local and national trends impacting behavioral health service delivery. It's been incredibly useful to have tangible resources on subjects including the integration of electronic health record systems, enhancing billing processes, outcome-based evaluation, and integrated health care, all in one place and yet shared within the context of a community of partners facing common challenges and goals. The impact of BHACA is evident within Catholic Charities' Counseling Services programs. During our participation in BHACA we have increased our private insurance billing, secured Medicare and Medicaid billing privileges, added to our outcomes tools, and started exploring integrated care options with medical providers.*

  ~Ernesto C. López, Jr., NCC, LPC-S, Program Director, Counseling Services, Catholic Charities of the Archdiocese of Galveston-Houston

SUCCESS AS RELATED TO ORIGINALLY PROPOSED GOALS

1. *We expect every behavioral health organization in Houston to have access to no-cost general information and education sessions that will allow them to assess their preparedness for the ACA. This education will, in turn, lead to increased knowledge/understanding of the ACA across the provider community.*

With a final tally of almost 2300 participants in BHACA events over the past three years and non-NBHP members and private practitioners accounting for over 350 of the entities represented, we believe that we can say with confidence that we provided accessible offerings. Throughout the first year, all of our general information sessions were free of charge to everyone. Once we began offering sessions on specific issues within each topic, the sessions were free to NBHP members as a membership benefit and available to nonmembers at a very nominal cost when CEU credits could be obtained. At the urging of our funders, about half way through the project we began charging small fees to everyone for the CEU credit sessions, offering discounted rates to members. It was our funders' recommendation that we start to collect program fees as a way of beginning to build a new income stream for NBHP.

As to the goal of increasing knowledge/understanding of the many changes brought about by healthcare reform, as reported above, half to three-quarters of our attendees reported gaining significant new knowledge across the five areas.

2. *We expect each organization that requests technical assistance from NBHP to be ready to meet the requirements for whichever mandate they have requested help.*

While we are unable to say with certainty that every person seeking technical assistance, either by attending a BHACA event, taking a class, participating in a networking group, or contacting us directly with a specific concern was then able to successfully meet the

requirement about which they were asking, we can say that we were able to successfully answer their questions and address their concerns. We know that, especially in the area of third party funding (50% of TA requests), technical assistance was a key factor in the success of that work agenda. And we know that the TA requests fielded by BHACA staff were only a part of the picture, as billing staff reached out to both their colleagues at other agencies as well as directly to the staff of the healthcare plans.

3. *We expect the number and the quality of integrated health care partnerships in greater Houston to grow and for these partnerships linking federally qualified health centers (FQHCs) and other community health clinics with behavioral health providers to successfully plan, implement, and sustain integrated health care services, serving as models for other communities.*

As described earlier, the initial focus on creating IHC partnerships was changed early on in the initiative to a broader focus on enhancing and increasing the delivery of integrated health care. Based on the findings discussed in this report, the BHACA Initiative has indeed helped advance integrated health care in greater Houston. As discussed, BHACA has supported agencies in different places along their IHC "journeys" in both the planning and implementation of integrated health care services. Overall, findings indicate a greater understanding of integrated health care and its importance among greater Houston behavioral health agencies, as well as movement towards more advanced levels of IHC.

As for serving as models for other communities, two presentations at the national Collaborative Family Healthcare Association (CFHA) annual conferences have shared relevant information. At the 2015 conference, BHACA staff presented on the IHC component of BHACA overall, including data from various participating agencies. At the 2016 conference, a BHACA staff member participated in a presentation focusing on one of the participating agencies' IHC services. As will be mentioned later in the report, the 2017 CFHA conference will be held in Houston; we expect this will provide a forum for additional BHACA agencies to showcase their IHC work.

4. *We expect MHA to gain even more knowledge about the process of integrated health care partnerships and to use that knowledge on as large a platform as possible.*

The BHACA Initiative has been an invaluable opportunity for MHA Greater Houston. In working with the participating agencies, planning educational events, researching relevant topics, etc., MHA Greater Houston has indeed increased its knowledge of integrated health care, its understanding of the IHC landscape in greater Houston, and its network of IHC contacts and experts. MHA is dedicated to using this knowledge and experience to continue to advance IHC in greater Houston and Texas.

In late 2015, MHA Greater Houston launched an initiative to bring together stakeholders to develop consensus recommendations in two areas critical to advancing IHC—financing/payment for IHC and provider preparation/workforce development for IHC. This initiative—now called the Integrated Health Care Initiative (IHCI)—would not have emerged without MHA's statewide and local experience supporting IHC. BHACA has been

the vehicle through which MHA's local experience in IHC has taken place, and thus the creation of the IHCI owes a great deal to BHACA. The IHCI recently released its recommendations report, available at http://www.mhahouston.org/files/1355/. As noted in the listing of organizational partners in the report, the Network of Behavioral Health Providers and several NBHP member agencies have participated as partners in the IHCI work. With its organizational partners, MHA is now moving into the next phase of the IHCI work, one of operationalizing, implementing, and advocating for the recommendations.

The knowledge and experience MHA has gained through the BHACA Initiative also helped put MHA in a strong position to help bring the Collaborative Family Healthcare Association (CFHA) annual conference to Houston in 2017. CFHA is a national, interdisciplinary association focused on integrated, collaborative care. Earlier this year, MHA successfully led an effort to advocate for Houston as the site of CFHA's 2017 conference. An MHA staff member is one of the chairs for the conference, which will take place in October 2017. Hosting the CFHA conference in Houston will not only bring national IHC expertise to the region, but will also allow for providers and other IHC stakeholders throughout the region and state to convene and learn from each other. The conference provides an opportunity to engage organizations, such as the institutions of the Texas Medical Center, toward the goal of advancing IHC in Houston and the state. The day before the conference, we will also have the opportunity to hold a state policy summit on integrated health care with support from the Eugene S. Farley, Jr. Health Policy Center. This will provide a forum for dialogue and action around relevant policy issues, such as those articulated in the recommendations report mentioned above.

5. *We expect NBHP to grow as an organization as the project reinforces to the behavioral health leadership in Houston the importance and value of a committed leadership forum that works together on behalf of the community.*

In July 2013, at the beginning of the BHACA Initiative, the organization's membership totaled 24 greater Houston behavioral health service providers. As the project was getting underway, three more agencies joined and those providers were included in the baseline member survey evaluation. At the midpoint of the project (January 2015), the membership had grown to 28 members. (Sadly we lost one member not just to NBHP but also to the community when their board voted to close down due to lack of funds.) As an interesting development directly due to BHACA, we had an agency in another Texas community ask to please be considered for membership due to the invaluable value added for their agency in just the Blast. In response, in June 2015, the membership approved the application of the Hays Caldwell Council on Alcohol and Drug Abuse. The Council's Executive Director and staff attended several BHACA events. Although the Council no longer appears on the NBHP roster, it is actually still involved because the Council came under the Cenikor Foundation umbrella in 2016 while Cenikor was in the process of submitting its membership application. In total, by the end of the BHACA timeframe, November 2016, NBHP has grown from 24 behavioral health provider entities to 39, an increase of 63%.

Table 3: 2013 to 2016 Network of Behavioral Health Providers Membership

Green = joined during year 1 **Red** = joined during year 2 **Blue** = joined during year 3

Member at Beginning of Year 1	Member at End of Year 2	Member at End of Year 3
Asian-American Family Services	**Baylor College of Medicine Teen Health Clinic**	**Baylor College of Medicine Teen Health Clinic**
Career and Recovery Resources	Career and Recovery Resources	**Behavioral Hospital of Bellaire**
The Center for Success and Independence	**Catholic Charities of the Archdiocese of Galveston-Houston**	Career and Recovery Resources
The Council on Recovery	The Center for Success and Independence	**Catholic Charities of the Archdiocese of Galveston-Houston**
DePelchin Children's Center	The Council on Recovery	**Cenikor Foundation**
Family Services of Greater Houston	**Covenant House Texas**	The Center for Success and Independence
Fort Bend Regional Council on Substance Abuse, Inc.	DePelchin Children's Center	The Council on Recovery
Harris County Psychiatric Center	**El Centro de Corazón**	**Covenant House Texas**
Harris Health System	Family Services of Greater Houston	DePelchin Children's Center
Houston Galveston Institute	Fort Bend Regional Council on Substance Abuse, Inc.	El Centro de Corazón
Houston Recovery Center	**Harris County Protective Services for Children and Adults**	Family Services of Greater Houston (Family Houston)
IntraCare Hospital	Harris County Psychiatric Center	Fort Bend Regional Council on Substance Abuse, Inc.
Jewish Family Service	Harris Health System	The Harris Center for Mental Health and IDD
Legacy Community Health Services	**Hays Caldwell Council on Alcohol and Drug Abuse**	**Harris County Protective Services for Children and Adults**
The Menninger Clinic	**Healthcare for the Homeless - Houston**	Harris County Psychiatric Center
Memorial Hermann Behavioral Health Services	**Houston Area Community Services, Inc. (HACS)**	Harris Health System
Mental Health America of Greater Houston	Houston Galveston Institute	**Healthcare for the Homeless-Houston**
MHMRA of Harris County	**Houston Methodist**	**Houston Area Community Services, Inc. (HACS)**
The Montrose Center	Houston Recovery Center	HGI Counseling Center

Santa Maria Hostel, Inc.	**Interface-Samaritan Counseling Centers**	Houston Recovery Center
SEARCH Homeless Services	IntraCare Hospital	**Interface-Samaritan Counseling Centers**
St. Joseph Medical Center	Jewish Family Service	IntraCare Behavioral Health
Vecino Health Centers	Legacy Community Health Services	Jewish Family Service
The Women's Home	Memorial Hermann Behavioral Health Services	**The Jung Center**
	The Menninger Clinic	**Krist Samaritan Center**
	Mental Health America of Greater Houston	Legacy Community Health
	MHMRA of Harris County	Memorial Hermann Behavioral Health Services
	The Montrose Center	The Menninger Clinic
	Open Door Mission	Mental Health America of Greater Houston
	Santa Maria Hostel, Inc.	The Montrose Center
	SEARCH Homeless Services	**Open Door Mission**
	St. Joseph Medical Center	Santa Maria Hostel, Inc.
	Vecino Health Centers	SEARCH Homeless Services
	The Women's Home	St. Joseph Medical Center
		SUN Behavioral Health
		Vecino Health Centers
		Volunteers of America Texas, Inc.
		West Oaks Hospital
		The Women's Home
Total: 24	**Total: 34**	**Total: 39**

Because we cannot assume that these remaining 15 new agencies joined NBHP solely due to the draw of the BHACA Initiative, we made a special effort to actually contact each of them and specifically ask what role if any did the existence of BHACA as a program of NBHP play in their decision to apply for membership and if BHACA met their expectations, once they had become a member. Of the 16 agencies, at least half of them said that BHACA was influential in their decision to join NBHP and that BHACA met their expectations. Of the agencies that did not report that BHACA was influential in their decision to join, they did

note that once they were introduced to BHACA, they were very pleased with the program. Members noted that it was nice to get the updates on trends and training opportunities provided by BHACA. One agency stated that they enjoyed the networking and collaboration opportunities with similar agencies that are seeking to improve the behavioral health environment for all providers and clients.

6. *We expect the number of low-income clients who are able to access both physical and behavioral health care to increase and for that care to be provided in a seamless fashion that puts the least burden on the clients and improves their physical and behavioral health care outcomes.*

When we began the BHACA Initiative, our vision was to create a vehicle that could assist every behavioral health provider in greater Houston who chose to participate in this effort in meeting the new health care reform changes. The goal of those changes was to provide all Americans with affordable, quality health care. Thus it seemed incumbent upon us to include a final goal that addressed that highest charge. Even as we crafted this goal, we knew that we would likely not be able to measure our success in any direct way simply because it was too far a leap to draw any kind of straight/direct line between our actual actions and the change in the numbers of low income individuals receiving care, change in the quality of that care, and ultimately improvement in their health. And any attempt to do so would be inappropriate.

That said, what we can argue, is that if the agencies that participated in BHACA made changes in the desired directions in the focus areas, those changes will have ripple effects because they have changed the system in which they are embedded in one way or another. So, for instance, if a behavioral health agency increases integration of primary care services (or vice versa), then the care coordination and communication between the behavioral health and the primary care clinicians becomes more seamless. If an agency understands the impact that increasing their third party funding stream will have on their overall revenue, they will begin to be more diligent in their work to increase the payers in that stream and the claims that they file. Successfully increasing the number of Medicaid/Medicare eligible clients means more low income persons having access. Adoption and full usage of a certified EHR impacts claims filing, the collection and analysis of client outcome data (quality of care), and the ability of patients to participate in their health care planning through the patient portal. In short, while there is no way to show a direct correlation between the learning and agency practice changes resulting from BHACA participation and the specifics of this goal, that learning was targeted specifically at aspects of agency operations change that ultimately are connected to the desired outcomes of the Affordable Care Act.

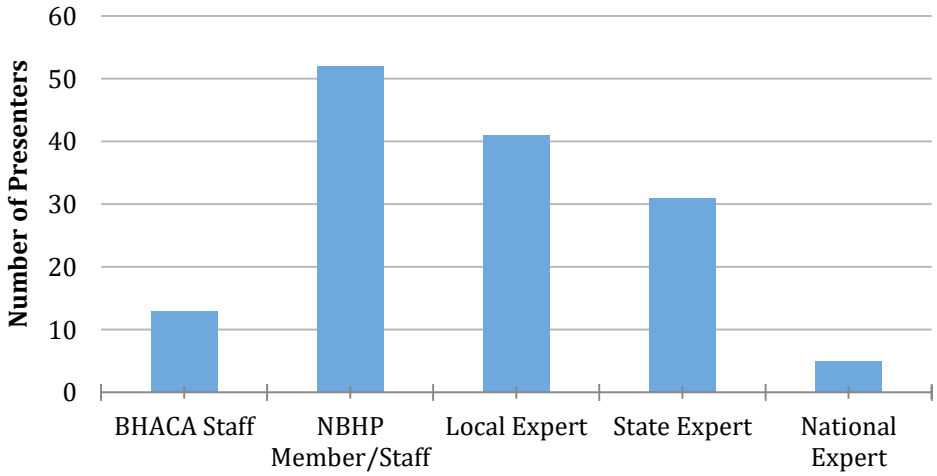
A Note on Using a Learning Community Approach Methodology

While not a goal in terms of outcomes, we do think it is important to provide outcome data on one of the major guiding principles of the BHACA model, using a learning community approach. We quickly discovered that our original plan to develop TA teams comprised of member agency staff (both within and cross agency) in each of the focus areas was not a

realistic approach. (In the baseline survey, members were asked if they had expertise in any of the four areas that they would be willing to share. In the responses, only 2 of 23 said yes in IHC, 6 in Third Party Funding, 5 in EHR, and 9 in Outcome-Based Evaluation (an ironic result considering that 16 of the 23 requested training in that area). Still committed to the idea of using local expertise whenever possible, we always looked first to who in our membership, then who in the community, then the state could fill our training and technical assistance needs. Only in those cases where we needed the "national" perspective, whether it be newly emerging practices (Data Visualization in evaluation reporting from the model experts in Michigan) or policies (Financing Integrated Health Care from a Vice President of the National Council for Behavioral Health), did we look to national resources.

As seen in Figure 18, we did stay true to our learning community approach with 75% of presenters being local (BHACA staff, NBHP member staff, or local expert) and half of those being member agency staff. Not only did this wealth of skills and expertise mean that dialogue with these individuals could continue beyond the actual event in which they participated, but we were able to offer significantly more activities because almost every one of these resource persons provided their services pro bono. When the results of these recruitment efforts are compared with the participants' rankings on the worthwhileness of our events (Figure 1), we think it is safe to say that use of local expertise did not affect the quality of the trainings and education offerings. Perhaps the most powerful example of the learning community we were able to create is exemplified by the testimony of Beacon Health Options, Manager of Provider Relationships whom we quoted above. In this specific case—the participation of payer staff alongside provider staff in the billing classes and ongoing networking meetings—learning took place on both sides of the relationship far beyond what anyone might have predicted.

Figure 18: Adherence to the Learning Community Model: Presenters by Locale



LESSONS LEARNED

We hope that is it clear from the data outcomes presented above that the effort and financial support contributed to the BHACA Initiative resulted in significant changes for the many providers involved and the greater Houston provider community as a whole. Besides the outcomes reflected in our data, however, we have also learned some very important things through the process of implementing this project and evaluating its impact.

Process Lessons

The power of real collaboration—Since the word "collaboration" entered our industry lexicon about two decades ago, many of us have participated in "collaborations" in one way or another. Many of us also know that a great number of those working agreements were far from what a true collaboration should be. Almost from the beginning of this project, the principals were aware that this partnership between NBHP and MHA was the "real thing." From the very first conceptual discussions through the analysis of exactly what the emerging data was telling us, every step of this work has been done in a collaborative fashion. While the Project Manager was an employee of NBHP, her time commitment was spread equally between the responsibilities of both collaborative agencies. All major project direction decisions were made as a team, all events were planned by the team, and all responsibility for outcomes, both positive and negative, were shared by the BHACA team. By modeling this very high level of collaborative planning and implementation, we believe that one of the overarching positive impacts of the project is the example we have set for the behavioral health provider community on the synergistic power of true collaboration. We cannot count the number of times that members of each agency have said, "If we weren't doing this together, there is no way we would have been able to come anywhere near creating and executing this tremendous project agenda." In addition, when this evaluation report is read through a collaboration lens, the reader will see that every one of the five areas of work had, at its core, a collaborative process with other community players in every step of its work.

Evidence of the impact of observing and participating in this collaborative endeavor on our participants can be seen in the emerging conversations and priority given to new collaborations among NBHP members. On the MHA side, their work on integrated health care has moved forward by leaps and bounds with the creation of a new phase of IHC work that is emerging out of a collaborative process.

The power of facilitation—In another form of connecting, we also discovered what a major role a massive education/support project can play in facilitating new relationships. Perhaps because Houston is so large and the provider community so spread out, provider staff don't know colleagues beyond their own agencies. We know from our work in NBHP for over a decade that providing opportunities for leaders to meet with their counterparts has resulted in new relationships, mutually discovered sources of information, and unexpected peer support for those executives. We had no doubt that providing education and technical assistance opportunities for other departments of those agencies' staff would likewise open new avenues of support. Billing staff that took our classes now call each other with their questions. Evaluation staff feel more confident in their efforts with Dr.

Watt's email address close at hand. Perhaps the most significant wall BHACA was able to break through was the one between provider and payer. These two entities have always been seen as adversaries with opposing charges—one to obtain as much reimbursement funding as possible and the other to retain as much of that funding as they can. Through BHACA, these two sides came to see that they actually have the same challenge—to provide funding for patient care when that care meets the criteria each side has been charged with meeting. While the two-way route is far from perfect, the long-held animosity by providers toward payers has been greatly reduced. The BHACA meeting opportunities allowed providers to hear and better understand the very specific and narrow guidelines that govern the decision-making of the payers. In addition, they witnessed payer representatives eager and more than ready to assist them when they did hit a wall. The current Community Health Choice claims denials rate of 10% or under for behavioral health is no accident; it is the product of hard work on both sides.

Unexpected Outcomes

This thing called "data"—There is simply no question that the collection of data to measure the impact and/or outcomes of any effort, be it a therapeutic intervention or a major initiative such as BHACA, is imperative. And, it goes without saying that it must be good data. Or does it? Our experience with the BHACA evaluation would lead us to suggest that the collection of "good" data is significantly more complicated than one might imagine. First, the number of moving parts in the BHACA Initiative that required measurement meant the creation of instruments to measure the impact/change in those parts was a massive effort. And respondents are not particularly happy responding to lengthy questionnaires. It is actually quite amazing that we ended up with the high numbers of responses we did.

The accuracy of the data in those responses is another question altogether, and the answers to that question help us see where we hit some snags and made some errors in our process of conducting the evaluation. First, our charge was to measure change over a period of three years. We did not think about the fact that, over that length of time, staff changes could occur, and persons who participated in early stages of the project and provided input on the evaluations might not still be around at the time of the subsequent iterations. In addition, we distributed the midpoint and final surveys to the NBHP members and urged them to recruit the appropriate staff (and reminded them of who those people were) to assist them in completing the various sections. It is our impression that many members did not necessarily ask the people who actually participated but used their own judgment about change in perceptions, activities and the impact of BHACA on those. Finally, we failed to consider providing members with their earlier midpoint evaluation answers as reference points. Thus while a respondent might feel that BHACA did increase their third party funding that they currently report to be 25%, they don't happen to remember that they answered that same question at midpoint with 40%. As a result, we had to go to the qualitative data and base some of our impact conclusions on information beyond what the simple bar graphs and yes and no answers would lead one to conclude.

Interpreting data: no simple answers—While many of our findings could be presented in the most simple of bar graphs, we knew that this very straightforward, simple graphic was not

telling the whole story, and our most difficult job was to look at the qualitative survey data, the comments of event participants, and the informal information we gathered along the way. For instance, in the case of our IHC work, some of our evaluation data points to a decrease in provision of IHC over the course of the project. However, knowledge of the agencies involved, along with data regarding the impact of BHACA on IHC provided at final survey, lead us to conclude that IHC services did not actually decrease in most cases. Rather, a strong case can be made that increased knowledge of IHC gained during the BHACA Initiative led agencies to realize that services that they had previously classified as integrated were not actually so.

Similarly, the acquisition of a certified EHR does not mean an agency can tick that box on their "to do" list. As Figure 11 shows, only 29% of NBHP members with EHRs say they use them to their full extent. Likewise, the pictures painted by the third party funding and outcome-based evaluation data graphics cannot accurately or adequately convey the complexity of the thought processes and actions behind the ultimate end points displayed in percentage bars.

Telling the whole story—We hope that the qualitative examples and case studies we have included in this report have made it clear how much we value this type of data, not only to further elaborate on the quantitative findings, but to underscore just how significant some of this work has been to some of the participants. In addition, the qualitative data has greatly helped us understand some of the quantitative findings that were not as straightforward as we had expected them to be. We are of the mindset that the success or failure of an effort lies in the numbers you can produce at the end of the effort. However, we are just as convinced that the stories behind those numbers, the colors they add to that sketch, is what makes the numbers come to life and completes the telling of the story.

The meaning of success—The question of goal achievement in each of the BHACA areas also does not always have a straightforward answer. The overarching goal of the focus area may not necessarily be a one size fits all. In the case of IHC, for example, beginning to plan for IHC can be a success for one agency, while advancing level of IHC might be a success for another. Purchase of an EHR may be deemed goal completion for the focus area, but for those many agencies that already have an EHR, expanding the usage of the various functionalities within the EHR is just as major an accomplishment. Indeed, on the question of how BHACA had influenced their EHR work, one provider who already had an EHR told us, "The organization's EHR has now been fully integrated into all sections of the practice," and another replied, "BHACA was influential in our thinking about how to integrate outcome measurements into our EHR." Sometimes, a seeming failure to achieve a stated goal is actually a success, case in point the earlier mentioned provider that went through the EHR consultation and was deemed by the consultant as needing only a data management system. The agency took that needs assessment and was able to make a strong and successful case to a funder for support of the purchase of that system.

Is it soup yet?—The work of BHACA was implemented over a three-year period. Much of that work was the planting of seeds of knowledge, encouragement to take action, support to embrace change. It can take a long time for these seeds to come to fruition. We must

remember that, just because an agency didn't make huge strides in a certain area doesn't mean that something hasn't impacted their thinking and will start to be evidenced in their planning towards the future. Moreover, agencies are dynamic, not static, entities. Who is to say that a long-held belief may not change or an organizational structure may not be deemed obsolete, and suddenly these issues are seen through a whole new lens. When the small faith-based agency joined NBHP three years ago at the start of BHACA, no organization could have been more adamant about their stance on not accepting any public money. Now, as BHACA is transitioning to a new agenda with a new identity, that agency is signing its first county contract. While all projects have results that no one could have foretold, such unanticipated outcomes (both positive and negative) are especially interesting in an effort of this size and with this reach.

LOOKING AHEAD/BUILDING ON THE WORK OF BHACA

Although the BHACA Initiative is formally over, in no way is the work generated by this effort ending. Indeed, it has given NBHP a strong, solid base on which to expand our work in training, technical assistance, and community-building. It has given MHA a strong community base of invested providers to help move its integrated health care work forward into a larger arena that includes public policy.

Specifically, we will continue to publish the Blast but retitle and expand issue coverage. The seven agencies who are still part of the EHR workgroup will continue to develop their group purchase proposal. The valuable collaborations developed between BHACA and the Houston Recovery Initiative, as well as between BHACA and the Southeast Texas Regional Healthcare Partnership (Medicaid 1115 Waiver), will also continue. Both NBHP and MHA will continue to be involved with these entities; the value and potential of continued collaboration is clear to all parties.

Time after time, in the discussion at NBHP monthly meetings, the members have expressed how valuable the organization has been to them in providing them a venue in which they can get to know their colleagues at a whole different level and different way than they would otherwise have just passing each other at the many meetings they all attend. Further, they have specifically stated that moving on after BHACA they want to see us develop such opportunities for other professional staff in their agencies, specifically clinical and financial staff. Clearly we have laid a strong foundation on which to do that. We believe, however, that they need to make clear to their staff that participation in such activities is of great value to them and support the time those happenings take away from their normal workload. While acknowledging their workload is first priority, we need to remind them that, just as it is for them, participating in NBHP-like entities is a form of self-care, and drawing strength and input from the only other people who truly understand what they deal with on a daily basis must be supported.

MHA Greater Houston will in turn carry forward elements of the BHACA Initiative related to integrated health care. As mentioned earlier, the Integrated Primary Care Behavioral Health Networking Group will continue. Combining aspects of the BHACA Blast and another regular email newsletter that MHA currently issues, MHA will continue to provide regular

email communications on IHC topics and resources. MHA will also continue to host educational events relevant to IHC. As previously mentioned, MHA is also expanding its work in integrated health care with the Integrated Health Care Initiative (IHCI), for which the Network of Behavioral Health Providers is one of the partnering organizations. The IHCI will work to advance integrated health care in Houston and Texas on a variety of levels, including policy.

A Final Note

In our efforts to summarize the outcomes for the various components of the BHACA Initiative and the many activities that were conducted in each area, we hope that we have been able to provide convincing evidence in these pages that this three-year collaborative effort was the success that we all hoped it would be. We know our reach was enormous, we know our programming was outstanding, and, most importantly, we believe that the members of the greater Houston behavioral health provider community are better equipped to deal with the massive changes in health care brought about by, not just public policy, but the improvements that technology and changing industry standards are requiring.

It is ironic that we began this work as the Affordable Care Act components were starting to become realities for our providers, and we are ending it as a new vision of health care delivery is poised to replace or revise much of that policy. In the face of these uncertainties, we believe that the work of BHACA stands and will continue to stand as time, money, and effort well-spent—because we have created a model that empowers a provider community to respond to changes, massive changes.

Regardless of what comes down the road over the next few years, greater Houston now has a behavioral health provider community that has created the collaborative environment it needs and developed the tools it will require to respond to those changes in a manner that is responsible, resourceful, and dedicated to ensuring that the health needs of its patients and clients and their families will be addressed to the very best of their abilities.

Appendix A – BHACA Event Table, Years 1 through 3

Year One							
Date	**Title**	**Keynote Speaker(s)**	**Total Number of Attendees and Agencies**	**Number of NBHP Attendees**	**Number of Non-Member Agency Attendees**	**Number of Private Providers**	**Number of Stakeholders**
10.3.13	The Affordable Care Act: Understanding and Implementing Its Requirements	-- Melissa Rowan, *Texas Council of Community Centers* -- Kim Szeto, *Asian American Family Services* -- Phil Beckett, *Greater Houston Healthconnect* -- Paul Lampi, *DePelchin Children's Center* -- Peggy Smith, *Baylor College of Medicine Teen Health Clinic* -- Jeanette Valdivieso, *Legacy Community Health Services*	81 participants 41 agencies	34	28	14	5
10.17.13	Integrated Health Care: From Concept to Practice	-- Alejandra Posada, *Mental Health America of Greater Houston* -- Andrea Washington, *The Montrose Center* -- Jennifer Mills, *DePelchin Children's Center* -- Marlisa Allen, *UT Physicians* -- Henry Salas, *Community Health Centers of South Central Texas* -- Andrea Richardson, *Bluebonnet Trails Community Services* -- Toni Watt, *Texas State University*	61 participants 36 agencies	27	23	4	7

Date	Title	Keynote Speaker, Consultant, or Workgroup Facilitator	Total Number of Attendees and Agencies	Number of NBHP Attendees	Number of Non-Member Agency Attendees	Number of Private Providers	Number of Stakeholders
11.21.13	Integrated Health Care: Implementation and Maintenance	-- Marshall Preddy, *Lone Star Circle of Care* -- Alejandra Posada, *Mental Health America of Greater Houston* -- Josefina Alcala, *The Center for Health Care Services* -- Greg Jensen, *Lone Star Circle of Care* -- David Buck, *Baylor College of Medicine* -- Katherine Sanchez, *University of Texas Arlington*	47 participants 24 agencies	18	21	4	4
12.6.13	The Impact of the ACA and Parity on Behavioral Health Providers' Financing Strategies	-- Ann Robison, *The Montrose Center* -- Mandie Eichenlaub, *MHMRA of Harris County* -- Delwin Beene, *Community Health Choice*	39 participants 18 agencies	15	16	4	4
2.5.14	Choosing a Certified Electronic Health Record	-- Nora Belcher, *Texas e-Health Alliance* -- Mary Beck, *The Council on Alcohol and Drugs Houston*	36 participants 23 agencies	20	12	0	4
2.19.14	Integrated Health Care Open Discussion Meeting	-- Alejandra Posada, *Mental Health America of Greater Houston* -- Elizabeth Reed, *Network of Behavioral Health Providers*	14 participants 5 agencies	3	5	3	3
2.26.14	Collaboration on Group Purchase of an EHR System	-- Mary Beck, *The Council for Alcohol and Drugs Houston, Inc.* (served as "expert"/ resource for the group given her experiences in selecting EHR)	15 participants 10 agencies	15	0	0	0

4.2.14	Understanding Approaches to Substance Use Treatment and Integration	-- Mary Beck, *The Council on Alcohol and Drugs Houston* -- Lauren Boe, *The Council on Alcohol and Drugs Houston* -- Cathy Crouch, *SEARCH Homeless Services* -- Andrea Washington, *The Montrose Center* -- Nadine Scamp, *Santa Maria Hostel, Inc.*	62 participants 27 agencies	27	24	3	8
4.23.14	IHC Open Discussion Meeting	-- Kerri-Anne Parkes, *UT Health*	10 participants 7 agencies	3	6	1	0
4.24.14	Rebooting Evaluation: From Tedious Exercise to Essential Change Agent	-- Toni Watt, PhD, *Texas State University*	42 participants 21 agencies	23	18	1	4
5.5.14	Site Visit to Integrated Health Care Partnership Clinic Bluebonnet Trails Community Services & Community Health Centers of South Central Texas	-- Andrea Richardson, *Bluebonnet Trails Community Services* --Henry Salas, *Community Health Centers of South Central Texas*	19 participants 11 agencies	7	11	0	1
5.23.14	Your Biggest Pain in the Neck Claims Denials: How to Reduce Them	-- Mandie Eichenlaub, *MHMRA of Harris County*	13 participants 8 agencies	13	0	0	0
6.6.14	Clinicians' Roundtable	-- Marion Coleman, *Network of Behavioral Health Providers*	20 participants 12 agencies	20	0	0	0

6.20.14	Privacy and Integrated Behavioral Health: Special Considerations Under HIPAA and Part 2	Marshall Preddy	60 participants 40 agencies	21	31	8	0

Year 1 Totals	Number of Events	Total Number of Speakers at Unique Events (Excluding BHACA Staff)	Total Participants at Unique Events	Total NBHP Member Staff Receiving Training at Unique Events	Total number of Unduplicated Member Agencies	Total Non-Members Receiving Training at Unique Events	Total number of Unduplicated Non-Member Agencies	Total Private Providers Receiving Training at Unique Events	Total number of Stakeholders at Unique Events
	14 events	34 speakers	519 participants	246 staff	28 member agencies	195 staff from non-member agencies	56 non-member agencies	42 private practice providers	40 stakeholders

YEAR TWO							
Date	**Title**	**Keynote Speaker, Consultant, or Workgroup Facilitator**	**Total Number of Attendees and Agencies**	**Number of NBHP Attendees**	**Number of Non-Member Agency Attendees**	**Number of Private Providers**	**Number of Stakeholders**
07.22.14	Electronic Health Record Group Workshop and Individual Agency Technical Assistance	- Amy Machtay, *Boughtin Orndoff Consulting*	32 participants 10 agencies	32	0	0	0
09.04.14	Fundamentals of Billing and Coding for Behavioral Health (4 sessions)	- Jeannie Helton, *Houston Community College*	18 participants 13 agencies	18	0	0	0
09.19.14	Behavioral Health Screening in Primary Care Settings: Integrated Health Care Models for Meeting Clients' Real-Time, Whole-Person Needs	- Stacy Ogbeide, PsyD, *Healthcare for the Homeless- Houston*	62 participants 34 agencies	22	40	0	0
09.24.14	Clinicians' Roundtable: Fall Gathering	- Jeanne Higgs, *LCSW, Recovery and Wellness Program Coordinator, The Montrose Center* - Ernesto Lopez, *NCC, LPC-S, Program Director, Counseling Services, Catholic Charities of the Archdiocese of Galveston-Houston* - Sergio Cruz, *LCSW, Clinical Supervisor, Catholic Charities of the Archdiocese of Galveston-Houston*	11 participants 8 agencies	11	0	0	0

10.09.14	Get Paid: Financing Integrated Health Care in Texas	-Kathleen (Kathy) Reynolds, *LMSW, ACSW, Vice President for Health Integration and Wellness, The National Council for Behavioral Health*	64 participants 38 agencies	11	49	4	0
10.24.14	Organizational Assessment Toolkit (OATI) for Primary and Behavioral Healthcare Integration	- Ken Minkoff, *Zia Partners, Inc.*	6 participants 3 agencies	3	0	0	2
10.16.14	Claims Denials for Behavioral Health (2 sessions)	Jeannie Helton, *Houston Community College*	22 participants 14 agencies	18	2	0	2
10.30.14	Physical Health 101: Understanding Physical Health for Behavioral Health Providers Part I: Diseases with Increased Prevalence in Patients Living with Severe Mental Illness	- Dr. John Oldham, MD, Senior Vice President and Chief of Staff, *The Menninger Clinic*	49 participants 24 agencies	14	28	7	0
11.13.14	Credentialing for Behavioral Health (2 sessions)	- Jeannie Helton, *Houston Community College* - Daniel Ramirez, *Beacon Health Strategies*	16 participants 10 agencies	13	2	0	1
12.04.14	Clinicians' Roundtable: A Tour of the Montrose Center	- Jeanne Higgs, *LCSW, Recovery and Wellness Program Coordinator, The Montrose Center*	7 participants 6 agencies	7	0	0	0
01.15.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	7 participants 6 agencies	6	0	0	1

12.04.14	Billing and Credentialing for Substance Use Services (2 sessions)	- Jeannie Helton, *Houston Community College*	12 participants 8 agencies	11	0	0	1
01.22.15	Fundamentals of Billing, Collecting, and Credentialing for Behavioral Health (3 sessions)	- Jeannie Helton, *Houston Community College* - Elizabeth Reed, *Network of Behavioral Health Providers* - Daniel Ramirez, *Beacon Health Strategies*	19 participants 13 agencies	13	6	0	0
2.12.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	8 participants, 6 agencies	7	1	0	0
02.17.15	Fundamentals of Billing, Collecting, and Credentialing for Behavioral Health (3 sessions)	- Jeannie Helton, *Houston Community College* - Elizabeth Reed, *Network of Behavioral Health Providers*	17 participants 10 agencies	8	9	0	0
02.19.15	Claims Denials for Behavioral Health (2 sessions)	- Jeannie Helton, *Houston Community College* - Mandie Eichenlaub, *MHMRA of Harris County*	9 participants 7 agencies	5	4	0	0
02.27.15	Integrated Primary Care Behavioral Health Networking Group	- Stacy Ogbeide, PsyD, *Healthcare for the Homeless-Houston*	13 participants 9 agencies	6	7	0	0
3.12.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	6 participants 5 agencies	5	1	0	0
03.26.15	Credentialing for Behavioral Health (2 sessions)	- Jeannie Helton, *Houston Community College* - Stephanie Gutierrez, *Catholic Charities*	9 participants 7 agencies	5	4	0	0

03.27.15	Clinicians' Roundtable: The DSM-5: Clinical Assessment, Diagnosis, and Supervision	- Joel Carr, Ph.D., LCSW, LPC, *MHMRA of Harris County*	167 participants 39 agencies	140	22	4	1
04.01.15	EHR Workgroup	- Marion Coleman, *Network of Behavioral Health Providers* - Mary Beck, COO, *The Council on Alcohol and Drugs—Houston* - Paul Lampi, Director of Business Development and Information Systems, *DePelchin Children's Center* - Linda Burger, CEO, *Jewish Family Service* - Amy Machtay, *Boughtin Orndoff Consulting*	8 participants 7 agencies	7	0	0	1
4.09.15	PQRS Webinar for Billing Medicare Part B: CMS Speaks to Greater Houston Behavioral Health Agencies	- Molly MacHarris *CMS* - Daniel Green, MD, *CMS*	25 Participants 8 agencies	9	12	4	0
04.16.15	ICD-10 for Behavioral Health (2 sessions)	- Jeannie Helton, *Houston Community College*	11 participants 7 agencies	10	1	0	0
4.17.15	How Medication Fits into the Pathways of Recovery: A Cross-Training on Medication Assisted Treatment (MAT) as an Option for Substance Use Recovery	- Barry E. Holzbach, *Alkermes, Inc.* - Michael Weaver *University of Texas-Pan America* - Christopher Ian Gage, *Unlimited Visions Aftercare, Inc.*	61 participants 29 agencies	22	34	3	2
5.8.15	Brief Behavioral Interventions in Primary Care: Billing	-Emilie Becker, MD, *Texas Medicaid and CHIP Program* -Katy Caldwell, *Legacy Community*	103 participants 30 agencies	35	55	4	9

	Considerations and Clinical Training	*Health Services* -Rodney McDonald, RN, MSN, *Centers for Medicare & Medicaid Services Medicare Fee for Service Branch Dallas Texas Regional Office* -Heidi Schwarzwald, MD, MPH, *Children's Health Plan, The Center for Children and Women Texas Children's Health Plan, Baylor College of Medicine Department of Pediatrics* -Alejandra Posada, M.Ed., *Mental Health America of Greater Houston* -Stephanie Chapman, PhD, Texas *Children's Health Plan – The Center for Children and Women* -Kavon Young, MD*, El Centro de Corazon* - Blanca Hernandez, PhD*, El Centro de Corazon* -Rodolfo Orna, LMFT*, El Centro de Corazon* -Stacy Ogbeide, PsyD *Healthcare for the Homeless – Houston*					
5.13.15	NBHP Billing Workgroup: Beacon Health Options Presents for NBHP Members and Selected Staff	- Daniel Ramirez, LMSW, *Beacon Health Options* - Ben Story, LCSW, *Beacon Health Options*	23 Participants 18 Agencies	19	4	0	0
6.5.15	Clinicians' Roundtable: The DSM-5: Clinical Assessment, Diagnosis, and Supervision	Joel Carr, Ph.D., LCSW, LPC, *MHMRA of Harris County*	89 Participants 21 Agencies	65	21	1	2

6.11.15	Safe Electronic Data: Managing Behavioral Health Client Confidentiality in the Age of Electronic Health Record Systems (EHRs), Health Information Exchanges (HIEs), and Coordinated Care	Phil Beckett, Ph.D., *Greater Houston Healthconnect* Mike Eber, J.D., M.P.H., *The Eber Law Firm, PLLC*	9 Participants 7 Agencies	7	2	0	0
6.19.15	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	Stacy Ogbeide, PsyD, *Healthcare for the Homeless-Houston*	15 Participants 9 agencies	8	7	0	0
6.22.15	NBHP Billing Workgroup	*Beacon Health Options (Corporate Headquarters via Webcast)*	14 Participants 10 agencies	11	2	0	1
6.24.15	BILLING, COLLECTING, AND CREDENTIALING FOR BEHAVIORAL HEALTH—in Austin	Mandie Eichenlaub, JD *MHMRA of Harris County* Gretchen Bieber, MHA, *Beacon Health Options* Elizabeth Reed, LMSW, *Network of Behavioral Health Providers, Greater Houston Behavioral Health Affordable Care Act (BHACA) Initiative*	36 Participants 24 Agencies	3	27	3	3
6.30.15	Interface-Samaritan Counseling Centers ICD-10 Staff Training	Mandie Eichenlaub, JD *MHMRA of Harris County* Elizabeth Reed, LMSW, *Network of Behavioral Health Providers, Greater Houston Behavioral Health Affordable Care Act (BHACA) Initiative*	28 Participants 4 Agencies	28	0	0	0

Year 2 Totals	Number of Events	Total Number of Speakers at Unique Events (Excluding BHACA Staff)	Total Participants at Unique Events	Total NBHP Member Staff Receiving Training at Unique Events	Total number of Unduplicated Member Agencies	Total Non-Members Receiving Training at Unique Events	Total number of Unduplicated Non-Member Agencies	Total Private Providers Receiving Training at Unique Events	Total number of Stakeholders at Unique Events
	32	**28**	**974**	**578**	**34**	**341**	**133**	**35**	**26**

YEAR THREE							
Date	**Title**	**Keynote Speaker, Consultant, or Workgroup Facilitator**	**Total Number of Attendees and Agencies**	**Number of NBHP Attendees**	**Number of Non-Member Agency Attendees**	**Number of Private Providers**	**Number of Stakeholders**
7.15.15	Clinician's Roundtable Summer Gathering	- Jeanne Higgs, *LCSW, Recovery and Wellness Program Coordinator, The Montrose Center* - Ernesto Lopez, *NCC, LPC-S, Program Director, Counseling Services, Catholic Charities of the Archdiocese of Galveston-Houston* -Natasha Bryant, *MA, LPC, Practice Manager Harris County Mental Health Jail Diversion Program* -Debbie Arnold, *LCSW, Manager, Counseling Services, DePelchin Children's Center*	9 participants 5 agencies	9	0	0	0
7.16.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	9 participants 5 agencies	9	0	0	0
7.23.15	Outcome-Based Evaluation Technical Assistance	-Toni Watt, *PhD, Professor of Sociology, Texas State University at San Marcos*	26 participants 14 agencies	25	1	0	0
8.27.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	8 participants 6 agencies	8	0	0	0
9.2.15	Outcome-Based Evaluation: Replacing the GAF and Selecting New Measures for Behavioral Health	- Joel Carr*, PhD, LCSW, LPC, UR/Quality Assurance Manager, MHMRA of Harris County*	22 participants 14 agencies	21	0	0	1
9.17.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	5 participants 4 agencies	4	0	0	1

9.21.15	Billing, Collecting, and Credentialing for Behavioral Health	- Elizabeth Reed, *Network of Behavioral Health Providers* - Mandie Eichenlaub, *United Healthcare* -Stephanie Ramirez, *The Council on Recovery* - Daniel Ramirez, *Beacon Health Options*	23 participants 14 agencies	12	8	1	2
10.2.15	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	-Dr. Katherine Bacon, *The Parris Foundation*	18 participants 12 agencies	8	8	1	1
10.27.15	Up Close and Personal with a Certified EHR: A Tour of PsychConsult Provider from Askesis Development Group by DePelchin Children's Center Staff	-Paul J. Lampi, *DePelchin Children's Center* Jennifer Mills, *DePelchin Children's Center* Neeta Potnis, *DePelchin Children's Center* Charles Doray, *DePelchin Children's Center*	28 participants 13 agencies	28	0	0	0
10.29.15	Billing and Credentialing Workgroup	- Elizabeth Reed, *Network of Behavioral Health Providers*	5 participants 5 agencies	4	1	0	0
11.19.15	Outcome-Based Evaluation Technical Assistance for NBHP Member Agencies: Workshop to Create a Program Logic Model	- Toni Watt, *PhD, Professor of Sociology, Texas State University at San Marcos* - Marion Coleman, PhD, *Network of Behavioral Health Providers*	9 participants 5 agencies	9	0	0	0
1.25.16	Billing and Credentialing Workgroup: Houston Area Face to Face TMHP Re-Enrollment Training	-Ben Story, *Beacon Health Options*	37 participants 12	7	10	20	0
2.5.16	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	-Dr. Stacey Ogbeide, *UT Health Science Center – San Antonio*	19 participants 11 agencies	5	11	3	0

2.12.16	DSM-5 Personality Disorders: The Current Approach and Alternative Model	-Dr. Joel Carr, *The Harris Center for Mental Health and IDD*	45 participants 12 agencies	41	3	0	1
2.25.16	Billing and Credentialing Workgroup	-Tracey Greenup, *The Network of Behavioral Health* -Daniel Ramirez, *Beacon Health Options*	4 participants 4 agencies	3	1	0	0
4.1.16	Addressing Substance Use Disorders in Primary Care: A New Frontier in Integrated Health Care	-Dr. Alicia Kowalchuk, *Baylor College of Medicine, Harris Health System*	57 participants 27 agencies	45	12	0	0
4.28.16	Billing and Credentialing Workgroup	-Tracey Greenup, *The Network of Behavioral Health* -Daniel Ramirez, *Beacon Health Options* -Courtney Harris, Amerigroup Texas	4 participants 4 agencies	2	0	0	2
5.11.16	Self-care Training for Harris County Protective Services	-Sandra Lopez, *University of Houston Graduate School of Social Work*	13 participants 1 agency	13	0	0	0
5.18.16	Trauma Informed Care: Implications for Clinicians and Institutions Stages of Treatment, Treatment Traps, Vicious Trauma	-Rosalie Hyde, *Houston Galveston Trauma Institute* -Naomi Rosborough, *Houston Galveston Trauma Institute*	33 participants 9 agencies	33	0	0	0
7.20.16	Trauma Informed Care: Implications for Clinicians and Institutions Stages of Treatment, Treatment Traps, Vicious Trauma	-Rosalie Hyde, *Houston Galveston Trauma Institute* -Naomi Rosborough, *Houston Galveston Trauma Institute*	40 participants 11 agencies	40	0	0	0
7.20.16	Integrated Health Care: An Introduction and Overview	-Alejandra Posada, *Mental Health America of Greater Houston*	21 participants 1 agency		21		

8.5.16	Implementing a Welcoming, Recovery-Oriented Integrated System of Care: Applying the Evidence to Practice	-Dr. Ken Minkoff	67 participants 31 agencies	38	25	4	0
8.18.16	Being a Clinician in a Legal World	- Brock Thomas, *338th District Court* -Sam Houston, -Ray Hays -Lisa Dahm -Lindsay Rene-Lopez -Regenia Hicks	90 participants 33 agencies	65	20	5	0
8.19.16	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	-Elaine Hess, *Healthcare for the Homeless-Houston*	7 participants 7 agencies	3	4	0	0
9.22-23.16	Motivational Interviewing	-Cathy Crouch, *SEARCH Houston*	13 participants 7 agencies	13	0	0	0
10.7.16	Jewish Family Service's tour of Credible	-Stephanie Tucker, *Jewish Family Services*	9 participants 6 agencies	9	0	0	0
10.13.16	Borderline Personality Disorder: Diagnosis and Treatment	-Dr. Joel Carr, *The Harris Center for Mental Health and IDD*	34 participants 14 agencies	32	2	0	0
10.20.16	Outcome Based Evaluation: Logic Models	- Toni Watt, *PhD, Professor of Sociology, Texas State University at San Marcos* - Marion Coleman, PhD, *Network of Behavioral Health Providers*	33 participants 8 agencies	33	0	0	0
10.20.16	Outcome Based Evaluation: Data Analysis	- Toni Watt, *PhD, Professor of Sociology, Texas State University at San Marcos* - Marion Coleman, PhD, *Network of Behavioral Health Providers*	15 participants 8 agencies	15	0	0	0

11.3.16	Data Visualization	Jennifer Lyons, LMSW, *Evergreen Data*	25 participants 16 agencies	20	4	1	
11.10.16	Integrated Healthcare: Children and Adolescents	Alejandra Posada *MHA Greater Houston (moderator)* Stephanie Marton, *MD, MPH, The Center for Children and Women-Greenspoint;* Jacquelyn McMillon, *MSW, LPC, LCSW Harris County Protective Services* Leslie Taylor, *PhD UT Physicians* Toni Watt, *PhD Texas State University*	25 participants 18 agencies	15	10	0	0
11.15.16	Billing and Credentialing Workgroup	-Tracey Greenup, *The Network of Behavioral Health* -Daniel Ramirez, *Beacon Health Options*	14 participants 10 agencies	12	4	0	0

Year 3 Totals	Number of Events	Total Number of Speakers at Unique Events (Excluding BHACA Staff)	Total Participants at Unique Events	Total NBHP Member Staff Receiving Training at Unique Events	Total number of Unduplicated Member Agencies	Total Non-Members Receiving Training at Unique Events	Total number of Unduplicated Non-Member Agencies	Total Private Providers Receiving Training at Unique Events	Total number of Stakeholders at Unique Events
	32	**32**	**766**	**582**	**34**	**142**	**73**	**35**	**13**

Year 1-3 Totals	Number of Events	Total Number of Speakers at Unique Events (Excluding BHACA Staff)	Total Participants at Unique Events	Total NBHP Member Staff Receiving Training at Unique Events	Total number of Unduplicated Member Agencies	Total Non-Members Receiving Training at Unique Events	Total number of Unduplicated Non-Member Agencies	Total Private Providers Receiving Training at Unique Events	Total number of Stakeholders at Unique Events
	78	**95**	**2,262**	**1,403**	**34**	**674**	**291**	**112**	**79**

Appendix B – BHACA Event Table by Focus Area

Type	Date	Title	Total Number of Attendees
-----	**10.3.13**	The Affordable Care Act: Understanding and Implementing Its Requirements	81
Clinicians' Roundtable	**6.6.14**	Clinicians' Roundtable	20
Clinicians' Roundtable	**9.24.14**	Clinicians' Roundtable: Fall Gathering	11
Clinicians' Roundtable	**12.4.14**	Clinicians' Roundtable: A Tour of the Montrose Center	7
Clinicians' Roundtable	**3.27.15**	Clinicians' Roundtable: The DSM-5: Clinical Assessment, Diagnosis, and Supervision	167
Clinicians' Roundtable	**6.5.15**	Clinicians' Roundtable: The DSM-5: Clinical Assessment, Diagnosis, and Supervision	89
Clinicians' Roundtable	**7.15.15**	Clinicians' Roundtable Summer Gathering	9
Clinicians' Roundtable	**2.12.16**	DSM-5 Personality Disorders: The Current Approach and Alternative Model	45
Clinicians' Roundtable	**5.18.16**	Trauma Informed Care: Implications for Clinicians and Institutions	33
Clinicians' Roundtable	**7.20.16**	Trauma Informed Care: Implications for Clinicians and Institutions	40
Clinicians' Roundtable	**8.18.16**	Being a Clinician in a Legal World	90
Clinicians' Roundtable	**9.22-23.16**	Motivational Interviewing	13
Clinicians' Roundtable	**10.13.16**	Borderline Personality Disorder: Diagnosis and Treatment	34
Total Clinicians' Roundtable Events	**12**	**Total Attendees**	**558**
Electronic Health Record	**2.5.14**	Choosing a Certified Electronic Health Record	36
Electronic Health Record	**2.26.14**	Collaboration on Group Purchase of an EHR System	15
Electronic Health Record	**7.22.14**	Electronic Health Record Group Workshop and Individual Agency Technical Assistance	32
Electronic Health Record	**4.1.15**	EHR Workgroup	8
Electronic Health Record	**6.11.15**	Safe Electronic Data: Managing Behavioral Health Client Confidentiality in the Age of Electronic Health Record Systems (EHRs), Health Information Exchanges (HIEs), and Coordinated Care	9
Electronic Health Record	**10.27.15**	Up Close and Personal with a Certified EHR: A Tour of PsychConsult	28
Electronic Health Record	**10.7.16**	Jewish Family Service's Tour of Credible	9
Total Electronic Health Record Events	**7**	**Total Attendees**	**137**

Integrated Health Care	**10.17.13**	Integrated Health Care: From Concept to Practice	61
Integrated Health Care	**11.21.13**	Integrated Health Care: Implementation and Maintenance	47
Integrated Health Care	**2.19.14**	Integrated Health Care Open Discussion Meeting	14
Integrated Health Care	**4.2.14**	Understanding Approaches to Substance Use Treatment and Integration	62
Integrated Health Care	**4.23.14**	Integrated Health Care Open Discussion Meeting	10
Integrated Health Care	**5.5.14**	Site Visit to Integrated Health Care Partnership Clinic (Bluebonnet Trails Community Services & Community Health Centers of South Central Texas)	19
Integrated Health Care	**6.20.14**	Privacy and Integrated Behavioral Health: Special Considerations Under HIPAA and Part 2	60
Integrated Health Care	**9.19.14**	Behavioral Health Screening in Primary Care Settings: Integrated Health Care Models for Meeting Clients' Real-Time, Whole-Person Needs	62
Integrated Health Care	**10.24.14**	Organizational Assessment Toolkit (OATI) for Primary and Behavioral Healthcare Integration	6
Integrated Health Care	**10.30.14**	Physical Health 101: Understanding Physical Health for Behavioral Health Providers	49
Integrated Health Care	**2.27.15**	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	13
Integrated Health Care	**4.17.15**	How Medication Fits into the Pathways of Recovery: A Cross-Training on Medication Assisted Treatment (MAT) as an Option for Substance Use Recovery	61
Integrated Health Care	**5.8.15**	Brief Behavioral Interventions in Primary Care: Billing Considerations and Clinical Training	103
Integrated Health Care	**6.19.15**	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	15
Integrated Health Care	**10.2.15**	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	18
Integrated Health Care	**2.5.16**	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	19
Integrated Health Care	**4.1.16**	Addressing Substance Use Disorders in Primary Care: A New Frontier in Integrated Health Care	57
Integrated Health Care	**5.11.16**	Self-care Training for Harris County Protective Services	13
Integrated Health Care	**7.20.16**	Integrated Health Care: An Introduction and Overview	21
Integrated Health Care	**8.5.16**	Implementing a Welcoming, Recovery-Oriented Integrated System of Care: Applying the Evidence to Practice	67
Integrated Health Care	**8.19.16**	Integrated Primary Care Behavioral Health Networking Group of Greater Houston	7
Integrated Health Care	**11.10.16**	Integrated Health Care: Children and Adolescents	25
Total Integrated Health Care Events	**22**	**Total Attendees**	**809**

Outcome-Based Evaluation	**4.24.14**	Rebooting Evaluation: From Tedious Exercise to Essential Change Agent	42
Outcome-Based Evaluation	**7.23.15**	Outcome-Based Evaluation Technical Assistance	26
Outcome-Based Evaluation	**9.2.15**	Outcome-Based Evaluation: Replacing the GAF and Selecting New Measures for Behavioral Health	22
Outcome-Based Evaluation	**11.19.15**	Outcome-Based Evaluation Technical Assistance for NBHP Member Agencies: Workshop to Create a Program Logic Model	9
Outcome-Based Evaluation	**10.20.16**	Outcome-Based Evaluation: Logic Models	33
Outcome-Based Evaluation	**10.20.16**	Outcome-Based Evaluation: Data Analysis	15
Outcome-Based Evaluation	**11.3.16**	Data Visualization	25
Total Outcome-Based Evaluation Events	**7**	**Total Attendees**	**172**
Third Party Funding	**12.6.13**	The Impact of the ACA and Parity on Behavioral Health Providers' Financing Strategies	39
Third Party Funding	**5.23.14**	Your Biggest Pain in the Neck Claims Denials: How to Reduce Them	13
Third Party Funding (Billing Class)	**9.4.14**	Fundamentals of Billing and Coding for Behavioral Health (4 sessions)	18
Third Party Funding	**10.9.14**	Get Paid: Financing Integrated Health Care in Texas	64
Third Party Funding (Billing Class)	**10.16.14**	Claims Denials for Behavioral Health (2 sessions)	22
Third Party Funding (Billing Class)	**11.13.14**	Credentialing for Behavioral Health (2 sessions)	16
Third Party Funding (Billing Class)	**12.4.14**	Billing and Credentialing for Substance Use Services (2 sessions)	12
Third Party Funding	**1.15.15**	NBHP Billing Workgroup	7
Third Party Funding (Billing Class)	**1.22.15**	Fundamentals of Billing, Collecting, and Credentialing for Behavioral Health (3 sessions)	19
Third Party Funding	**2.12.15**	NBHP Billing Workgroup	8
Third Party Funding (Billing Class)	**2.17.15**	Fundamentals of Billing, Collecting, and Credentialing for Behavioral Health (3 sessions)	17
Third Party Funding (Billing Class)	**2.19.15**	Claims Denials for Behavioral Health (2 sessions)	9
Third Party Funding	**3.12.15**	NBHP Billing Workgroup	6
Third Party Funding (Billing Class)	**3.26.15**	Credentialing for Behavioral Health (2 sessions)	9
Third Party Funding	**4.9.15**	PQRS Webinar for Billing Medicare Part B: CMS Speaks to Greater Houston Behavioral Health Agencies	25
Third Party Funding (Billing Class)	**4.16.15**	ICD-10 for Behavioral Health (2 sessions)	11
Third Party Funding	**5.13.15**	NBHP Billing Workgroup: Beacon Health Options Presents for NBHP Members and Selected Staff	23
Third Party Funding	**6.22.15**	NBHP Billing Workgroup	14
Third Party Funding (Billing Class)	**6.24.15**	Billing, Collecting, and Credentialing for Behavioral Health—in Austin	36
Third Party Funding	**6.30.15**	Interface-Samaritan Counseling Centers ICD-10 Staff Training	28

Third Party Funding	**7.16.15**	NBHP Billing Workgroup	9
Third Party Funding	**8.27.15**	NBHP Billing Workgroup	8
Third Party Funding	**9.17.15**	NBHP Billing Workgroup	5
Third Party Funding (Billing Class)	**9.21.15**	Billing, Collecting, and Credentialing for Behavioral Health	23
Third Party Funding	**10.29.15**	NBHP Billing Workgroup	5
Third Party Funding	**1.25.16**	NBHP Billing Workgroup: Houston Area Face to Face TMHP Re-Enrollment Training	37
Third Party Funding	**2.25.16**	NBHP Billing Workgroup	4
Third Party Funding	**4.28.16**	NBHP Billing Workgroup	4
Third Party Funding	**11.15.16**	NBHP Billing Workgroup	16
Total Billing Classes	**11**	**Total Attendees**	**192**
Total Third Party Funding Events	**29**	**Total Attendees**	**507**

Appendix C – Examples of Technical Assistance

Examples OF TA:

Third Party Funding
One of the NBHP member agencies was being denied re-credentialing by a payer due to the fact that they lacked a Medical Director. This organization does not provide any medical care but the payer reported that it still required a Medical Director to be on staff. One of the billing staff at this agency who was part of the billing networking group presented the issue to BHACA staff. Staff reached out to the provider relations contact at the healthcare plan. The contact took the issue to the appropriate person in the insurance company and was able to get an exception to the requirement and have the recertification approved.

Our provider relations contact at Beacon Health Options routinely attended billing networking meetings after completing the billing classes. Based on this continuing contact and assistance, this contact reports that he now regularly receives calls from NBHP agency staff with questions and has been able to answer questions, research unclear directives, and most importantly, help them process claims that had been earlier denied.

Certified EHR
A member asked about the data security of mobile devices and various other technical issues (screenshots, electronic signatures, etc.) The BHACA Project Manager shared this request with staff and, after discussion with other NBHP members, determined that there were a number of questions regarding security/HIPAA compliance. BHACA staff took these concerns to Greater Houston Healthconnect, and their Vice President and an attorney specializing in cyber security issues provided a training for member agencies.

Outcome-Based Evaluation
A member requested technical assistance in beginning to develop outcome measures for their agency's programs. BHACA staff connected the member with two other agencies with similar service populations who were already doing outcome-based evaluation. Staff also provided the member with several outcome measures that had been researched by the BHACA evaluator.

Samples of TA Interactions:

Sample 1 – Third Party Funding & Integrated Health Care – TA to Montrose Center re: SAMSHA Certified Community Behavioral Health Clinic (CCBHC) Initiative

(Note: This example is most interesting because Dr. Robison received the additional information obtained by the BHACA IHC lead, Alejandra Posada, from HHSC and went on to apply. The Montrose Center was just named the first CCBHC in the state of Texas. Obviously

she might have applied anyway, but we were pleased to be able to provide her with this additional information.)

On 9/4/2015 11:22 AM, Elizabeth Reed wrote:
Dear NBHP Members, NBHP Billing Workgroup, and Affiliate Partners,

BIG NEWS -- Texas HHSC has applied to SAMHSA to be 1 of 25 states awarded a 1-year planning grant around creating **Certified Community Behavioral Health Clinics (CCBHCs).** Texas will hear mid-September if they win the grant. Twenty-five states will be awarded 1-year planning grants (covering the period from Oct. 2015 to Sept. 2016). After that one year of planning, 8 states will be awarded a 2-year demonstration grant.

CCBHCs are the behavioral health equivalent of FQHCs. It is big news that Texas wants to, and has applied to, be one of the states moving in this direction.

We encourage all available BH providers to join the below webinar (Monday, Sept. 21, 10am to 11am CDT) to learn more and stay up to date on this as it develops.

For entities to qualify as CCBHCs -- note the emphasis discussed below on integrated health care, new payment models, and alignment with MCO standards, all of which are tied to BHACA focus areas. We hope and trust that BHACA has prepared NBHP provider entities well to be able to take advantage of these upcoming opportunities or to move further in that direction. The potential creation of CCBHCs is a serious new carrot driving progress toward integrated health care in Texas.

PS Of note, BHACA's next billing class (Sept. 21st) is the same day as webinar mentioned below -- so if you're able to participate in the webinar, please take good notes for those of us who will be teaching class! :)

Thanks,
Elizabeth

Elizabeth Reed, LMSW
Project Manager
Greater Houston Behavioral Health
Affordable Care Act Initiative (BHACA)

From: Ann J Robison, PhD [mailto:arobison@montrosecenter.org]
Sent: Monday, September 21, 2015 10:35 AM
To: Elizabeth Reed
Cc: Marion Coleman; Alejandra Posada
Subject: Re: BIG NEWS for NBHP Providers -- Texas HHSC Applies to SAMHSA for Planning Grants for Certified Community Behavioral Health Clinics (CCBHCs)

I'm listening to the webinar now. There apparently was one on the 18th as well listing the items that needed to be turned into DSHS by the 2nd in order to be considered as a site. Do we have the contact person at DSHS or HHSC who is writing this? I could only listen to the webinar as the link I had was bad.

From: Alejandra Posada [mailto:aposada@mhahouston.org]
Sent: Monday, September 21, 2015 11:29 AM
To: Todd,Jay (HHSC)
Cc: Elizabeth Reed
Subject: Webinars today and on the 18th

Hello Jay,

I am a colleague of Elizabeth Reed, with whom you exchanged e-mails last week. I listened to the webinar today over the phone but was unable to view the slides. Would it be possible to send me the PowerPoint from today's webinar? Also, we would be very interested in seeing the PowerPoint and receiving any information from the webinar on the 18th, particularly information regarding what centers/providers need to do by the 18th to be considered for CCBHC designation. As Elizabeth mentioned when she wrote last week, we work with a number of behavioral health provider organizations that may be interested in this opportunity, if they meet the requirements.

Have a lovely day!

Thank you,
Alejandra

On 9/21/2015 4:04 PM, Alejandra Posada wrote:
Hello Ann,

Jay Todd from HHSC sent me the information below as well as the attached PDF of the PowerPoint.

Have a lovely afternoon!

Thank you,
Ale

From: Todd,Jay (HHSC) [mailto:Jay.Todd@hhsc.state.tx.us]
Sent: Monday, September 21, 2015 3:37 PM
To: Alejandra Posada
Cc: Elizabeth Reed
Subject: RE: Webinars today and on the 18th

Alejandra –

The powerpoints are similar – though the one today was focused for MCOs. Here is information that was sent to the centers that participated in the webinar on the 18th, including a .pdf of the powerpoint.

Jay

I appreciate the interest and response to the recent webinar and follow-up about the Texas plan for the SAMHSA Planning Grant for Certified Community Behavioral Health Clinics. Per request from many participants, attached is a .pdf file of the webinar from September 18, 2015.

I am re-attaching last week's follow-up e-mail as well. In addition, several questions have been received since the webinar and I wanted to share the answers with you all.

Q: *What type of demographic information would you like included in letters of interest?*
A: In terms of demographic information, we are interested in the characteristics of your client base - definitely include age/race, and percent of clients that are Medicaid. If you have information about the breakdown of BH and SUD clients served, that would also be helpful.

Q: *Can you speak more about the requirements for clinics to provide detox services?*
A: The RFA talks about a CCBHC addressing detox services in two ways –

1) As part of coordination of care, CCBHCs must have "partnerships or formal contracts with the following……(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs,
2) As part of crisis behavioral health services, "services provided must include…services capable of addressing crises related to substance abuse and intoxication, including ambulatory and medical detoxification."

Q: *Is it possible to have a DCO perform to crisis services and/or detox services?*
A: As outlined by SAMHSA, the clinic is responsible for providing crisis services, not a DCO - since the ambulatory and medical detoxification services are associated with crisis services, that would also not be a service that could be handled by a DCO. This can be validated with SAMHSA after notice of award to see if there is flexibility in that requirement.

From: HHSC HPCS CCBHC Project
Sent: Friday, September 18, 2015 3:45 PM
Subject: Overview of the Texas CCBHC Project - Follow-up

Thank you for participating in today's webinar *Overview of the Texas Certified Community Behavioral Health Clinic Project*.

We are excited about the opportunities that this project offers. These include:

- An opportunity for HHSC, MCOs, BHOs and Community Centers to test a health home model for behavioral health – in a risk free manner for participating clinics during a 2 year demonstration period that ensures that all parties are made whole;
- An opportunity to test a non- fee for service payment model that is designed to enable greater flexibility and innovation by the clinics;
- The use of a clinical model that could save MCOs and BHOs medical costs;
- The opportunity for MCOs to collect population and utilization information for a 2 year period, and leverage that information to refine payment models.
- Provide an expansion of value based payments for MCOs.

As mentioned during the webinar, please submit your interest to participate in this exciting project to this e-mail address by October 2. Submissions should include:

- Readiness self-assessment
- Overview of clinic including populations served, org chart and number of clinics (established prior to April 1, 2014)
- Identification of DCOs that are in place
    - Statement about ability to pay DCOs for services
- MCOs that the clinic contracts with to provide Medicaid services
- Ability to financially track and operate with an alternative PPS structure
- Current DSRIP or other State behavioral health project involvement
- Statements about ability and turn-around time to provide cost and ongoing evaluation reports for up to 5 years

If you have questions about the project, please e-mail them to HPCS_CCBHCProject@hhsc.state.tx.us .

Thanks again for your interest and commitment to behavioral health excellence in Texas.

From: Ann J Robison, PhD [mailto:arobison@montrosecenter.org]
Sent: Monday, September 21, 2015 8:54 PM
To: Alejandra Posada
Cc: Elizabeth Reed personal
Subject: Re: FW: Webinars today and on the 18th

since they didn't advertise the webinar on the 18th outside of the CMHCs, do we have any info on how to get on the list of interested not-for-profits?

Sent: Tuesday, September 22, 2015 9:04 AM
To: 'Ann J Robison, PhD'
Cc: Elizabeth Reed personal
Subject: RE: FW: Webinars today and on the 18th

Hi Ann,

It's my understanding that any interested organization (whether a CMHC or a not-for-profit) can get on the list by sending an e-mail indicating interest to HPCS_CCBHCProject@hhsc.state.tx.us by October 2. The e-mail should include the following information:

- Readiness self-assessment
- Overview of clinic including populations served, org chart and number of clinics (established prior to April 1, 2014)
- Identification of designated collaborating organizations (DCOs) that are in place
    - Statement about ability to pay DCOs for services
- MCOs that the clinic contracts with to provide Medicaid services
- Ability to financially track and operate with an alternative PPS structure
- Current DSRIP or other State behavioral health project involvement
- Statements about ability and turn-around time to provide cost and ongoing evaluation reports for up to 5 years

According to Jay, the PowerPoints used for the two presentations were basically the same (in fact, I think he attached the one from the 18th). So, I don't think CMHCs received any additional info about how to indicate interest. Highlighted below, there is a question about the submission of interest (specifically, about demographic info needed) that someone asked. That, along with the list above (also highlighted below) appears to be the only information that's been shared about indicating interest. Jay did say that any questions could be directed to him or to HPCS_CCBHCProject@hhsc.state.tx.us, so I imagine people may be asking more questions, the answers to which he may send out to everyone on his list. I'll forward anything I receive, but it might not hurt to send him a quick e-mail asking him to add you to his list so you receive any updates of that nature.

Have a good day!

Thank you,
Ale

Sample 2 – Integrated Health Care – TA to Interface Samaritan CEO, w/response

From: Elizabeth Reed [mailto:nbhp.elizabeth@gmail.com]
Sent: Friday, September 18, 2015 2:53 PM
To: Steve Duson
Cc: Alejandra Posada; Marion Coleman

Subject: Integrated Health Care Resources from BHACA
2
Hi Steve,
Thanks again for suggesting the call this afternoon -- it was great to talk, and please keep us looped in regarding any follow-up ways to be of support.
As promised, I am sending a few resources that may be helpful as you go into the board meeting tomorrow.
1. Below is an email from Jay Todd at Texas HHSC inviting managed care organizations and

managed behavioral health organizations to join on a conference call this coming Monday, September 21, from 10am to 11am. HHSC is trying to engage managed care organizations in Texas to discuss Texas's application to SAMHSA for a one-year planning grant concerning the development of Certified Community Behavioral Health Clinics (CCBHCs) and a prospective payment system (PPS) for behavioral health services provided for Medicaid clients by those certified clinics. While this call is intended for MCOs, we have encouraged those providers who are interested to eavesdrop on the conversation in order to get a better understanding.
2. This is the article I discussed regarding behavioral health providers assuming some risk in order to partner with primary care for integrated health care through accountable care organizations (ACOs).
"Given all of this experience, what was the best advice from our panel for integrating with an [Accountable Care Organization (ACO)]? Develop organizational corporate relationships by reaching out to executives managing ACOs with a proposed model for addressing behavioral health for their members. Our panelists suggested these tips when talking with a potential ACO partners:
1. "Provide both "head" and "heart" reasons for your partnership. Data is critical to an ACO, but they also want to know what is in it for their consumers.
2. "Be clear about the geography that your organization can cover. A partnership won't work if consumers aren't willing or able to travel to your practice.
3. "Be willing to take on some risk. This is a business model, and you're going to have to be willing to help front load some of the cost. Acknowledge that the ACO may not be able to pay very well, but that you understand the benefits of the increased number of referrals to your practice."
Full article: https://www.openminds.com/market-intelligence/executive-briefings/finding-the-opportunities-for-behavioral-health-in-acos.htm/

3. This is the "Partnership Checklist," a 3-page document which is one of the tools in the OATI Toolkit (Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration) published by the SAMHSA-HRSA Center for Integrated Health Solutions. This tool is recommended for organization's internal reflection when considering possible integrated health care partners, and may also be used alongside those prospective partners to flesh out shared ideas, etc.

- Full Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration (OATI) Tool: http://www.integration.samhsa.gov/operations-administration/assessment-tools#OATI
- Partnership Checklist: http://www.integration.samhsa.gov/operations-administration/OATI_Tool1_Partnership_checklist.pdf

4. Attached is the information that BHACA put together for behavioral health organizations that would like to consider partnering with a physician from the Family Medicine Department of Baylor College of Medicine. We now recall that we did not put into writing the possible hourly rates, and as it has been a year we may need to ask after them again, but this is at least an avenue that could be of interest to explore further.
5. This is more information about Harris Health System's Patient-Centered Medical Home designation via the National Committee for Quality Assurance (NCQA): https://www.harrishealth.org/en/news/pages/medical-home-designation.aspx.
6. This is information about Medicaid health homes -- an option Texas has not yet pursued but

may in the future:
State Has Not Yet Seized ACA Opportunity to Establish Medicaid Health Homes to Provide More Efficient and Higher Quality Care: Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to provide comprehensive, coordinated care for Medicaid beneficiaries **who have a serious and persistent mental health condition**; have two or more chronic conditions; or have one chronic condition and are at risk for a second. **Chronic conditions explicitly listed include mental health, substance abuse**, asthma, diabetes, heart disease, and being overweight. Various types of providers – **including community mental health centers or other behavioral health providers** – can serve as Health Homes. The health team **must include behavioral health professionals**. States have flexibility to determine the specifics of the model as well as the payment methodologies. Sixteen states now have approved State Plan Amendments for Health Homes, but Texas has not yet done this. (April 2015 data)

Thanks!
Elizabeth

Elizabeth Reed, LMSW
Project Manager
Greater Houston Behavioral Health
Affordable Care Act Initiative (BHACA)

This is awesome – thanks so much, Elizabeth.

Steve.

Interface-Samaritan
COUNSELING CENTERS

Steve Duson | Executive Director
4803 San Felipe | Houston, TX 77056
713-626-7990, x104
www.interface-samaritan.org

Sample 3 – Third Party Funding – TA call for input, w/response

Outgoing message from Tracey to the billing group listserv:

Good morning! The following question was posed to us by a member organization and we were hoping to get insight from the members of the billing listserv. CMS policy allows physicians, providers, and suppliers to charge Medicare beneficiaries for missed appointments. This is provided they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. In addition, the rule states that the charges for Medicare and non-Medicare patients must be the same.

If you bill Medicare, how do you handle the discrepancy between what you can charge a full fee (or private insurance client) for a missed appointment and what you can charge an indigent (non-Medicare) client whose negotiated fee may be as little as $15? (i.e. doesn't the above CMS guideline force a consistent flat fee for both? If so, how do you set that fee?).

If you can offer any guidance or insight, please let us know.
Tracey

Incoming response from Dennis (CFO) at Krist Samaritan:
Please see the section of our intake policy below for our cancelation fee policy. (section attached via pdf)

Sample 4 – Integrated Health Care – TA to Texas Children's Pediatrics, w/response

From: Joyner, Jamil Prentice [mailto:jp127562@bcm.edu]
Sent: Friday, August 21, 2015 4:47 PM
To: Susan Fordice; Alejandra Posada
Subject: Texas Children's Pediatrics Follow up

Hello Susan and Alejandra,
I hope you are doing well. I wanted to give you an update on how TCP has been doing since my Capstone project last year. I am proud to announce that we are opening a Behavioral and Wellness Clinic. This was not a direct result of my project but I think it is a step in the right direction. Please see the attached flier. The clinic will be run by Dr. Barnhart, a Pediatrician who has over 40 years of experience in primary care. He is currently a Pediatrician at TCP Kingwood. He has a special interest in Behavioral Health and wants to spend more time with patients. Right now, the clinic does not have a Behavioral Health provider yet. Our leadership wants to see how the clinic goes before adding an FTE.
As a result of my project, Baylor College of Medicine will be hiring a psychologist to go half time to TCP Grand Parkway and half time at another TCH facility in Sugarland. This will be our pilot program on collocated care. We are hopeful it goes well.
One of our social workers plans to get Dr. Barnhart connected with BHACA events. Aside from BHACA, do you know of any training opportunities for nurses who want to learn more about Behavioral Health? Since he will not have licensed Behavioral Health providers at the beginning, I am wondering if his nurses can provide some education. For example, can they learn how to teach families how to advocate for schools? Can they teach patients how to create a schedule, write down their homework lists, and other simple Behavioral interventions?

From: Alejandra Posada
Sent: Monday, August 24, 2015 5:34 PM
To: 'Joyner, Jamil Prentice'; Susan Fordice
Subject: RE: Texas Children's Pediatrics Follow up

Hello Jamil,

I hope you are doing well!

Thanks so much for sending this update. I am excited to hear about this progress.

We would be more than happy to get Dr. Barnhart connected with BHACA activities. I look forward to hearing from him and/or your social worker.

I think it's a great idea to have the nurses provide some behavioral education in the absence of a behavioral health provider. My experience has been that nurses tend to "get" integrated care and really help facilitate its progress.

A few resources from recent BHACA presentations may be of interest:

--The recording from a training on "Behavioral Health Screening in Primary Care Settings," available at http://www.mhahouston.org/behavioral-health-screening/. This training was provided by Stacy Ogbeide, PsyD, the Behavioral Health Consultant with Healthcare for the Homeless; she is one of the most knowledgeable people I know in this area.

--From a training on "Brief Behavioral Health Interventions in Primary Care," the attached resource sheet (particularly the second page listing clinical resources).

We also have some training opportunities "in the works" that may be of interest. We'll be sending updates through the BHACA blasts. I'd also be happy to talk with Dr. Barnhart or any of his colleagues to see if there are other ways that we can help meet their training needs, including possibly putting them in touch with nurses who are familiar with this kind of work and who might be good resource persons.

I am excited to see both the Behavioral and Wellness Clinic and the co-located pilot progress! If my colleagues and I can be of any assistance, please don't hesitate to let us know.

Have a lovely day.

Take care, and thank you,
Ale

Alejandra Posada, M.Ed.
Director of Education and Training

RESPONSE:
-----Original Message-----
From: Joyner, Jamil Prentice [mailto:jp127562@bcm.edu]
Sent: Tuesday, August 25, 2015 12:18 PM
To: Alejandra Posada
Subject: RE: Texas Children's Pediatrics Follow up

Wow! This is such a great wealth of information. I have forwarded it to our CMO and Dr. Barnhart. He said he will be reaching out once the dust settles. Their clinic is set to go live September 1.

Thanks again,
Jamil

Appendix D – Integrated Health Care Rating Tool

The following two pages contain a copy of the tool used to rate level of integration at midpoint and final surveys. The tool was created by BHACA staff based on the SAMHSA-HRSA Center for Integrated Health Solutions' six-level framework for integration.

Agencies were asked to fill out separate tools for their overall agency services as well as for each distinct program or partnership providing integrated care to a subset of their population. A distinct integration score was calculated for each tool filled out.

For each tool filled out (so, for each distinct integration program/partnership, or for an agency's overall services), the distinct integration score presented in the report was calculated by averaging the scores/levels selected for the various domains listed on the tool. For the "Facilities" domain, agencies selecting "In separate facilities" were given a score of 1.5 for the domain, since the description is the same for integration levels 1 and 2. Scores were rounded to one decimal point.

The following is a hypothetical example to illustrate how the scores were calculated:

Domain	**Score/Level Selected by Agency**
Facilities	3
Communications	4
Collaboration	4
Meetings	3
Roles	5
Resources	2
Systems/Electronic Health Record	2
Treatment Plans	3
Treatment Delivery	3
Patient Experience	3
Leadership Support	5
Provider Buy-in	4
OVERALL SCORE (AVERAGE)	**3.4** (41 ÷ 12 = 3.417, rounded to 3.4)

	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 a Transformed/Merged Integrated Practice**
Behavioral health, primary care and other healthcare providers						
Facilities	<———— In separate facilities ————>		In same facility not necessarily same space	In same space within the same facility	In same space within the same facility, with some shared practice space	In same space within the same facility, sharing all practice space
Communications	Communicate about cases only rarely	Communicate periodically about shared patients	Communicate regularly about shared patients, by phone or e-mail	Communicate in person as needed	Communicate frequently in person	Communicate consistently at the system, team and individual levels
Collaboration	Communicate, driven by provider need	Communicate, driven by specific patient issues	Collaborate, driven by need for each other's services	Collaborate, driven by need for consultation and coordinated plans for difficult patients	Collaborate, driven by desire to be a member of the care team	Collaborate, driven by shared concept of team care
Meetings	Provider team may never meet in person	Provider team may meet as part of larger community	Provider team meets occasionally to discuss cases due to close proximity	Provider team has regular face-to-face interactions about some patients	Provider team has regular team meetings to discuss overall patient care and specific patient issues	Provider team has formal and informal meetings to support integrated model of care
Roles	Inter-disciplinary providers have limited understanding of each other's roles	Inter-disciplinary providers appreciate each other's roles as resources	Inter-disciplinary providers feel part of a larger yet ill-defined team	Inter-disciplinary providers have a basic understanding of roles and culture	Inter-disciplinary providers have an in–depth understanding of roles and culture	Inter-disciplinary providers have roles and cultures that blur or blend
Resources	No sharing of resources	May share resources for single projects	May share facility expenses	May share office expenses, staffing costs, or infrastructure	Variety of ways to structure the sharing of all expenses	Resources shared and allocated across whole practice

Systems/ Electronic Health Record (EHR)	Separate scheduling, charting, and (as applicable) EHR systems. Data may be communicated but this exchange across systems is rare	Separate scheduling, charting, and (as applicable) EHR systems. Periodic exchange of data about particular clients	Separate scheduling, charting, and EHR systems, yet separate systems have means of "talking to each other," through a continuity of care document or a local health information exchange (i.e. Greater Houston Healthconnect)	Behavioral health and other healthcare providers share some systems in common, such as scheduling, charting, or (as applicable) EHRs, and separate systems have means of "talking to each other"	Behavioral health and other healthcare providers share all systems in common, including scheduling, charting, and EHRs; however, some inefficiencies in EHR design may make accessing all patient data cumbersome	Behavioral health and other healthcare providers share all systems in common, including scheduling, charting, and EHRs. All data is readily accessible to all providers
Treatment Plans	Separate treatment plans	Separate treatment plans shared based on established relationships between specific providers	Separate treatment plans with some shared information	Collaborative treatment planning for specific patients	Collaborative treatment planning for all shared patients	One treatment plan for all patients
Treatment Delivery	Patient physical and behavioral health needs are treated as separate issues	Patient health needs are treated separately, but records are shared periodically	Patient health needs are treated separately at the same location	Patient health needs are treated separately at the same site, collaboration might include warm hand-offs	Patient needs are treated as a team for more complex patients but not for all patients	A team treats all health needs for all patients
Patient Experience	Patient must negotiate separate practices and sites on their own	Patients may be referred, but a variety of barriers prevent many patients from accessing care	Close proximity allows referrals to be more successful and easier for patients	Patients are internally referred with better follow-up	Care is responsive to identified patient needs by a team of providers as needed, which feels like a one-stop shop	Patients experience a seamless response to all healthcare needs
Leadership Support	No coordination or management of collaborative efforts	Some leadership in more systematic information sharing	Organization leaders supportive but often colocation is viewed as a project or program	Organization leaders support integration through mutual problem-solving of some system barriers	Organization leaders support integration, if funding allows, and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced	Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
Provider Buy-in	Little provider buy-in to integration or even collaboration, up to individual providers to initiate	Some provider buy-in to collaboration and value placed on having needed information	Provider buy-in to making referrals work and appreciation of onsite availability	More buy-in to concept of integration but not consistent across providers	Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	Integrated care and all components embraced by all providers and active involvement in practice change

Appendix E – A Note on the Challenges of Quality Measures

There are over 500 behavioral health quality measures today. Measures have been created by various institutions, most notably the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Quality Assessment and Improvement in Mental Health (CQAIMH). There are also measures in existence that have been constructed by local organizations and agencies and other health focused institutions. The fragmented creation of these measures has created several issues. A fair amount of the 500+ behavioral health quality measures are duplicates. This stems from variations in measure definition as well as the variation in parameters of care indicated by a certain measure.

Additionally, the fragmentation has created measures that are not always supported by evidence-based research. Some of this can be attributed to the number of scientific studies conducted around specific health conditions and corresponding measures. Others, however, may be evidence-based but are not practical tools in assessing patient care within a healthcare institution.

The slow uptake of health information technology systems has also contributed to the disjointed and repetitive measures in behavioral health. Inadequate data systems only provide a limited description of services, and so further data must be pulled from claims data, paper records or clinical notes in order to obtain the data necessary for outcome measures. Additionally, data systems are important to the implementation of the best practices and benchmark measures to track client health outcomes. Integrated data systems and data sharing networks would facilitate the collaboration of providers and standardization of both care and measures. Capable data systems would also enhance the ability of providers to analyze the effectiveness of services and track any patterns or variations in care provided and patient health outcomes. Many NBHP members have EHR systems that do not currently have the capacity to do this in-depth analysis, or lack the staff resources to implement this analysis within their EHR.

Within this environment of measures, behavioral health performance has been noted as lagging behind that of other healthcare fields. For two-thirds of payers tracking performance metrics from 2006-2014, the average performance of behavioral healthcare providers has declined.