



NATIONAL ASSOCIATION OF
Community Health Centers



***NACHC 2010 Assessment of
Behavioral Health Services
In Federally Qualified Health
Centers***

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

**2010 ASSESSMENT OF BEHAVIORAL HEALTH SERVICES PROVIDED
IN FEDERALLY QUALIFIED HEALTH CENTERS**

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Executive Summary

Federally Qualified Health Centers (FQHCs) provide comprehensive primary health care and behavioral health services (mental health and substance abuse) to all patients regardless of their ability to pay or their health insurance status. Located in medically underserved areas, FQHCs are a critical component of the health care safety net. FQHCs serve patient populations that are predominantly low-income, minority, and uninsured or rely heavily on public insurance. Over 1,250 health centers operate approximately 8,000 sites throughout the United States and territories. In 2010, FQHCs will serve an estimated 20 million patients. The demand for health services provided by FQHCs is expected to increase over time. With the passage of the 2010 Patient Protection and Affordable Care Act, the nation's health care reform legislation FQHCs may serve 40 million patients by 2015. According to Uniform Data System (UDS) reports, the system FQHCs use to report to the Health Resources Services Administration (HRSA) each year over 70% of health centers provide behavioral health services. Few studies, however, have assessed the level of behavioral health integration present in health centers.

The *NACHC 2010 Assessment of Behavioral Health Services in FQHCs* seeks to identify to what degree health centers have attained integration of services. The parameters used to ascertain integration include Co-location of behavioral health and medical services, good Communication and Collaboration between behavioral health and medical providers, Access to behavioral health Treatment Plans by medical and behavioral health staff, Access to Problem Lists by medical and behavioral health staff, Access to Medication Lists and Lab work and Joint Decision Making by medical and behavioral health staff on patient treatment. The assessment also sought to better understand behavioral health staffing in health centers and the training needs identified by FQHCs that they feel are important in improving the quality of care that they provide and increasing their capacity to provide integrated behavioral health services.

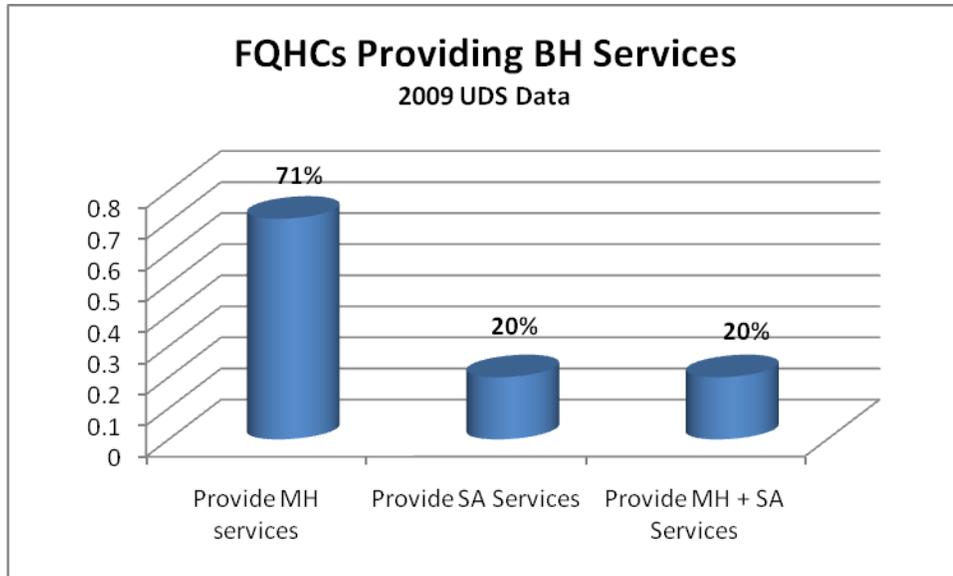
The assessment findings indicate several important areas for consideration and future action:

- The majority of FQHCs that responded, almost 65%, meet all of the components of integrated care i.e. services are Co-Located on site, they have good Communication and Coordination among behavioral health and primary care providers, they share Behavioral Health Treatment Plans, share Problem Lists and Medication and Lab results and behavioral health and medical providers make Joint Decisions on patient treatment.
- Mental health services are provided by over 70% of the FQHCs centers, however, Substance Abuse services are provided at only 55% of the health centers that responded
- While only 10% of the FQHCs do not routinely screen for depression over 35% of the FQHCs do not routinely screen for substance abuse
- FQHCs are utilizing evidenced based tools for screening for mental health and substance abuse

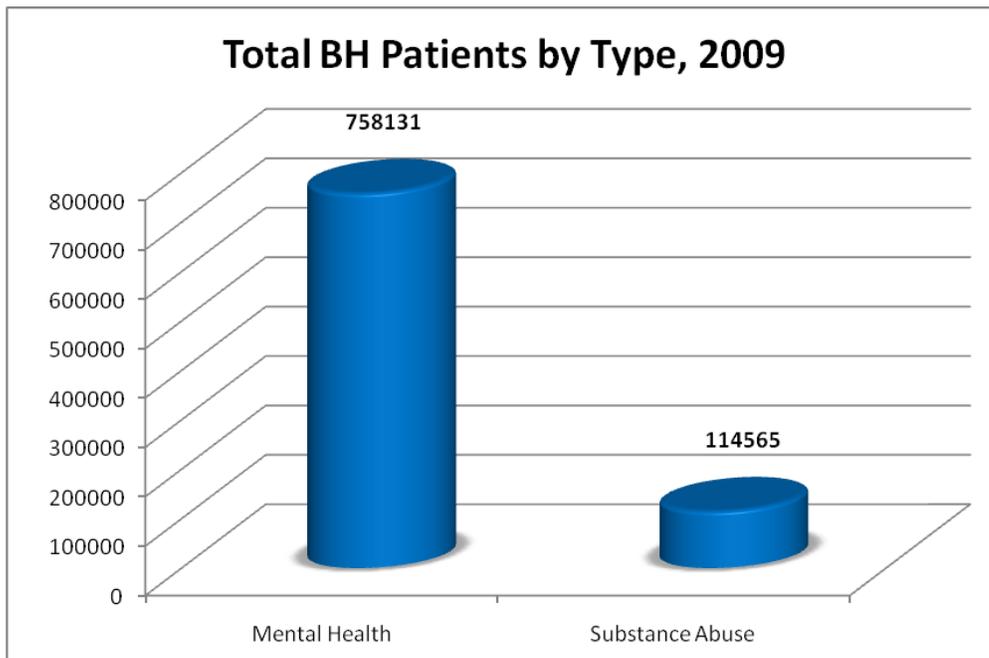
- Only 40% of the FQHCs provide mental health services at all of their sites and only 32% provide substance abuse services at all of their sites
- Social Workers are the predominant behavioral health discipline represented in FQHCs while Psychologists are under represented in FQHC environments
- Although medically assisted treatments for opiate abuse are provided at only 15% of the FQHCs that responded 43% identified that at least one MD at their center would take the mandated DEA course to provide these services
- The areas of training most frequently requested by health centers in the clinical realm include Training medical providers on behavioral health disorders, Short Term Interventions, Problem Focused Treatment, Motivational Interviewing, Screening Brief Intervention and Referral to treatment (SBIRT) and PTSD and trauma interventions
- The areas of training most frequently requested by FQHCs in non clinical areas include Managing No Shows and Reimbursement/Coding

There are a number of recommendations to assist FQHCs to provide higher quality of care and increase their capacity to provide behavioral health services which include 1) conducting further analysis to determine the barriers to implementing behavioral health services at all FQHC sites; 2) continuing to work with SAMHSA and HRSA to bring medically assisted treatment training to FQHCs; 3) advocating for expansion of other licensed behavioral health providers (in addition to social workers and psychologists) as being approved billable providers in FQHCs; 4) provide more education and training to FQHCs on the use of evidence based screening tools; 5) provide education and training to FQHCs in key clinical areas that will assist them to improve the quality of care they provide; and 6) provide education and training on administrative aspects of care to assist health centers to provide more sustainable behavioral health services.

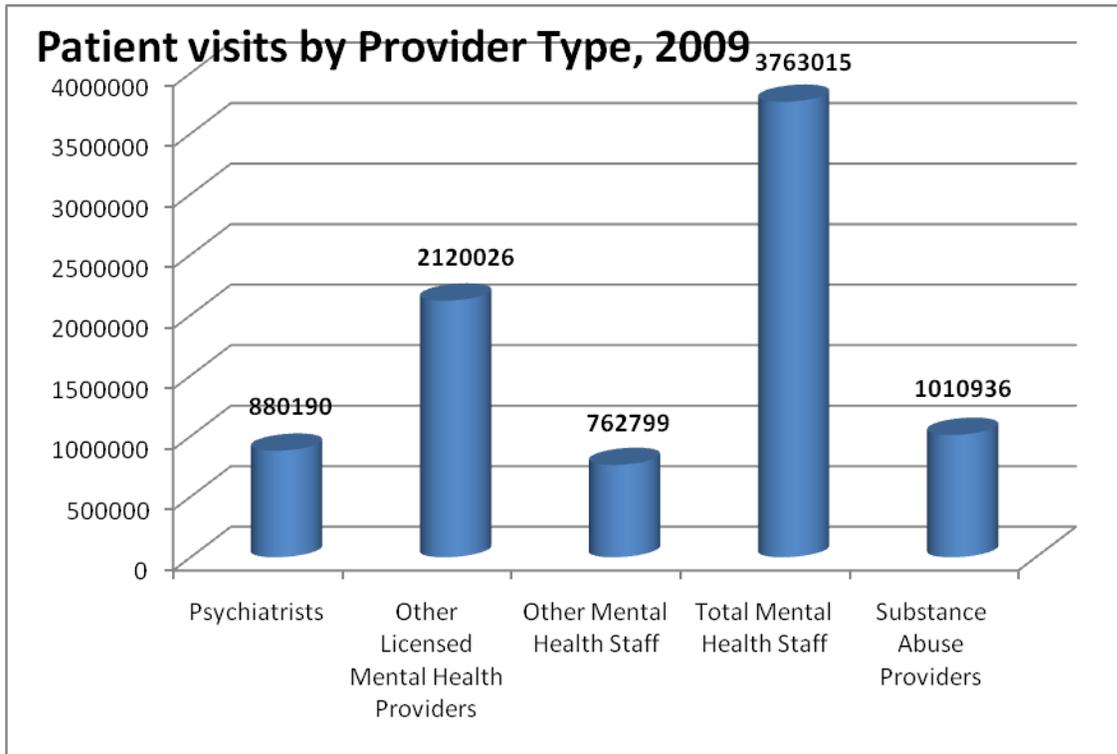
Federally Qualified Health Centers (FQHCs) have been providing behavioral health services (mental health and substance abuse) for many years. 2009 UDS data reported by health centers indicates that over 70% of health centers provide mental health services, 20% provide substance abuse services and 20% provide both mental health and substance abuse services.



FQHCs served over 870,000 individual patients for behavioral health disorders providing services to 758,131 individual patients for mental health disorders and 114,565 for substance abuse disorders.



In terms of actual behavioral health visits FQHCs provided 4,773,951 behavioral health visits in 2009. Visits provided by Provider Type are identified below.

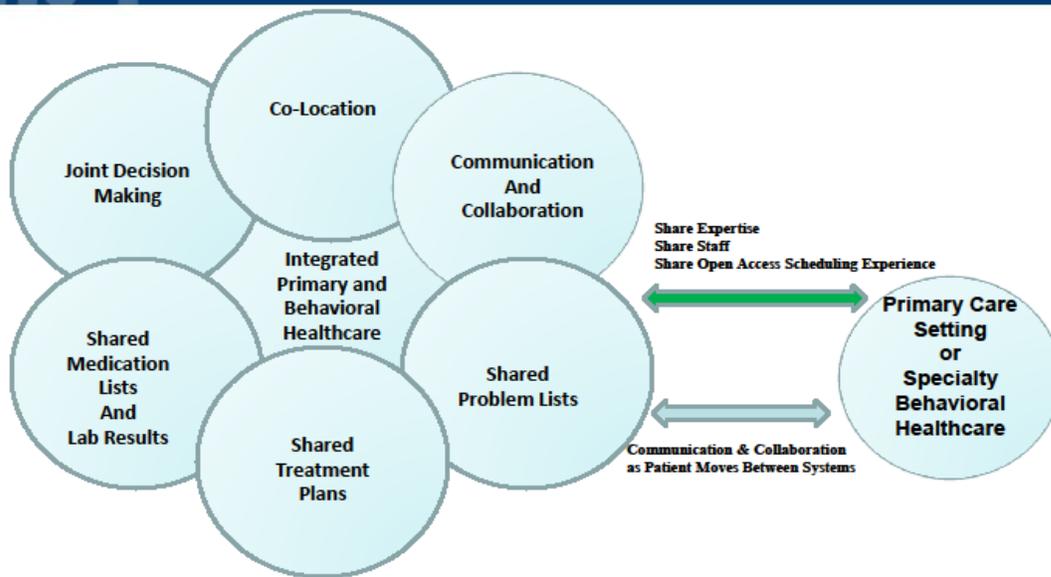
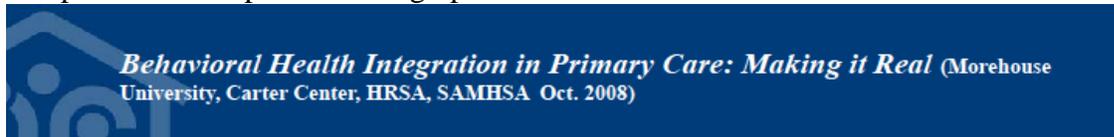


Information on the level of integration of behavioral health services in FQHCs, barriers to integration and training and support required by FQHCs to further integrate behavioral health services are not well documented. This assessment was developed to identify the current state of integration in FQHCs and to assist in developing training to address the needs of health centers to assist in future integration efforts.

The Assessment of Behavioral Health Services in Federally Qualified Health Centers (Developed by NACHC , unpublished) is a 56 item assessment that explores primary care and behavioral health (mental health and substance abuse) integration. This assessment was sent to 1080 FQHCs in late February 2010 and was open for response through July 2010. The assessment focuses on the areas of staffing, service provision, screening practices, provider-to-provider communication, care coordination, decision-making authority, staff training and technical assistance needs in Federally Qualified Health Centers (FQHCs). This assessment also attempts to determine the degree to which behavioral health services are “integrated” in Federally Qualified Health Centers (FQHCs). Prior to distribution the instrument was developed in collaboration with four FQHCs representing small, large, rural and urban centers, an outside consultant and HRSA and BPHC staff.

In a meeting sponsored by the Carter Center and Morehouse University in October of 2009 “*Behavioral Health Integration: Making it Real*” which was convened by federal partners and

co chaired by Dr. Ken Thompson of SAMHSA and Dr. Don Weaver of HRSA, government, for profit, non profit providers and associations representing behavioral health and primary care providers were invited to share experiences and best practices regarding integrated behavioral health and primary care services. Observations from this meeting identified that the core components of successful behavioral health and primary care integration included **Co-Location of Services, Communication and Coordination** of treatment between the primary care and behavioral health providers, **Shared Treatment Plans, Shared Problem Lists, Shared Medication and Lab Results**, and **Joint Decision Making** around patient care. These core components are depicted in the graphic below.



Core Components of Successful Integrated Models

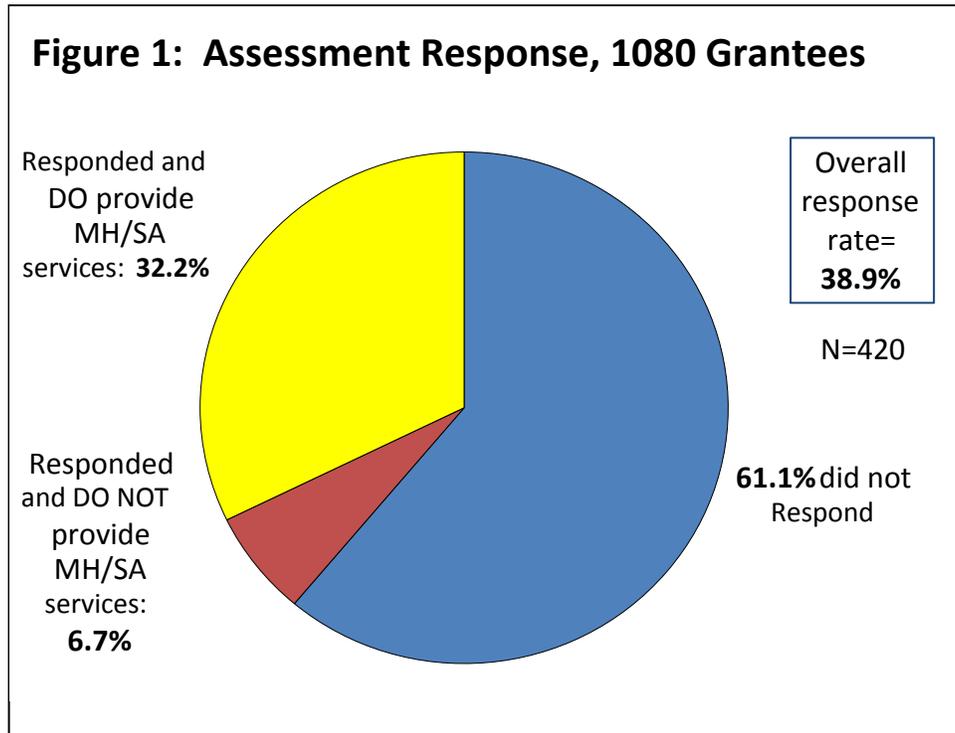
M. Lardiere – National Association of Community Health Centers 12/2008

Response Rate

There were 420 non-duplicate responses, yielding a 38.9 percent response rate of the total 1080 FQHCs assessed (see Figure 1). The assessments were completed by the CEO, COO or Other Administrative Staff in 47.1% of the responses, by Behavioral Health Administrators or Staff in 39.4% of the responses and by Other Clinical Staff in 12.6% of the responses. Other Staff responded in 0.9% of the responses.

Of the respondents, 72 FQHCs (17.1 percent) reported that they do not provide mental health or substance abuse services, which precluded them from completing the assessment. The remaining 348 grantees reported that they do provide mental health or substance abuse services onsite or

maintain formal linkages with specialty mental health or substance abuse providers in the community.¹



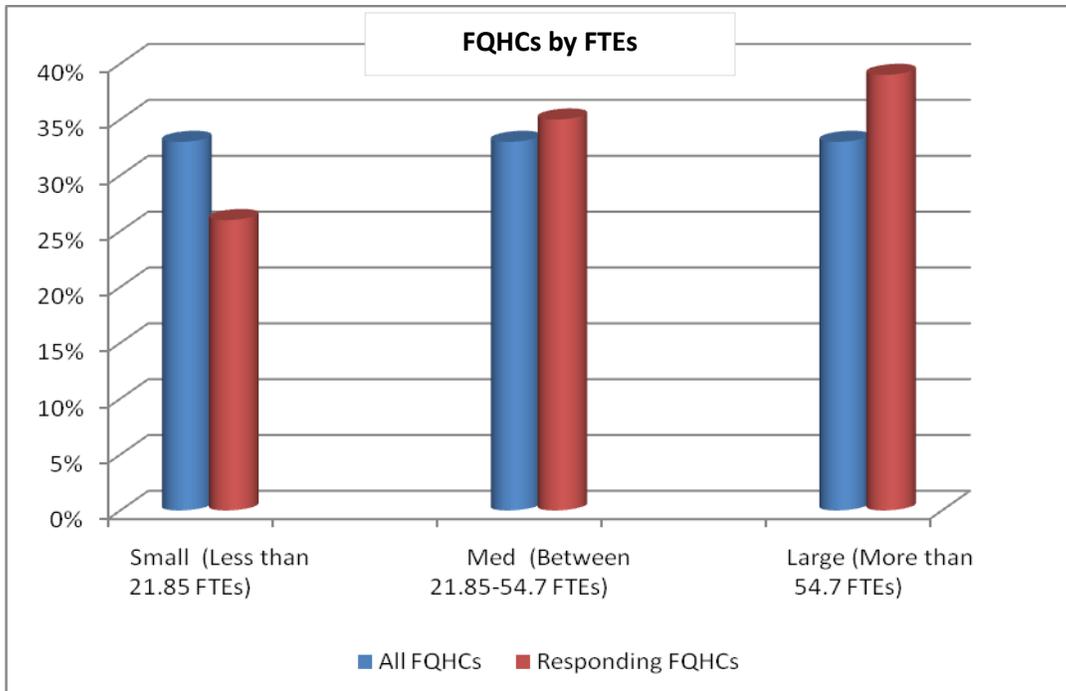
This analysis focuses on the 348 FQHC respondents that do provide mental health and/or substance abuse services. Of these, 346 provide mental health services. Only two do not provide mental health services. 192 of the 348 respondents provide substance abuse services. Respondents that offer substance abuse services are likely to also have mental health services; only two FQHCs that offer substance abuse services do not offer mental health services.

Representative Sample

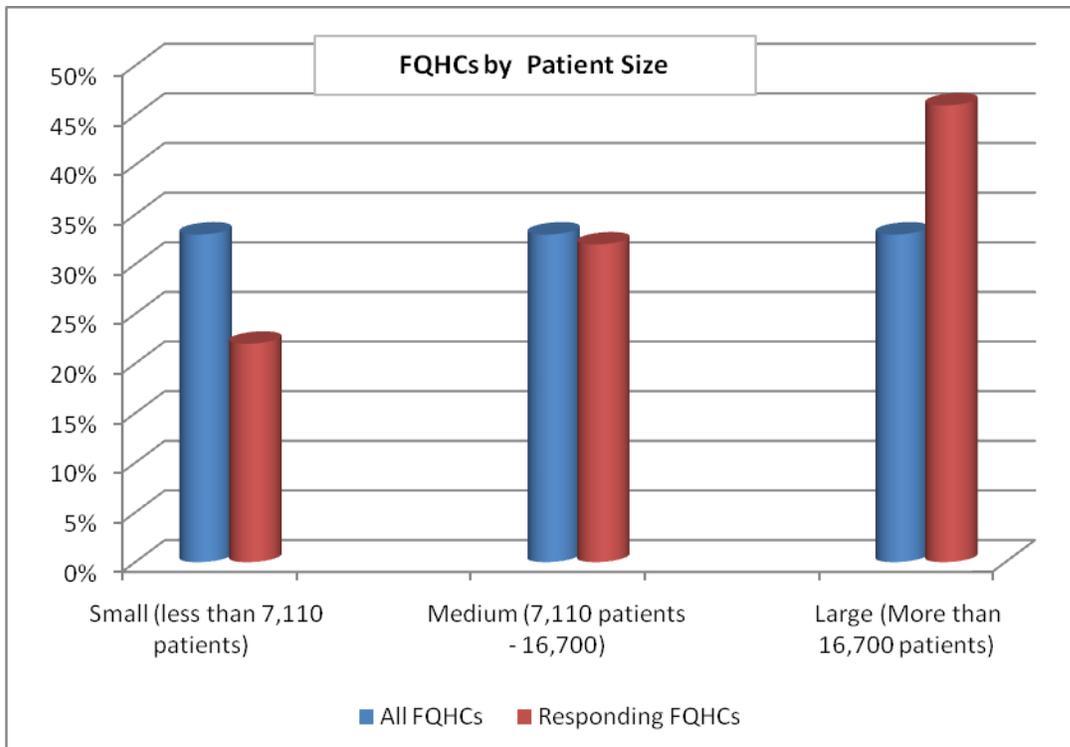
When we compared the assessment respondents to FQHCs nationally, the respondents are a representative sample of the FQHC's at a national level.

Compared to FQHCs nationally measured by numbers of clinician FTEs 26% of the responding FQHCs fell into the Small FQHC category (under 21.85 FTEs), 35% in the Medium category (21.85 – 54.7 FTEs) and 39% in the Large FQHC category (over 54.7 FTEs).

¹ The question asks: “Does your health center provide mental health or substance abuse services? Unless otherwise noted, by “provide” we mean the service is performed at the health center or at one of its sites AND/OR the health center pays for the service to be performed elsewhere because the health center does not perform the service itself.”



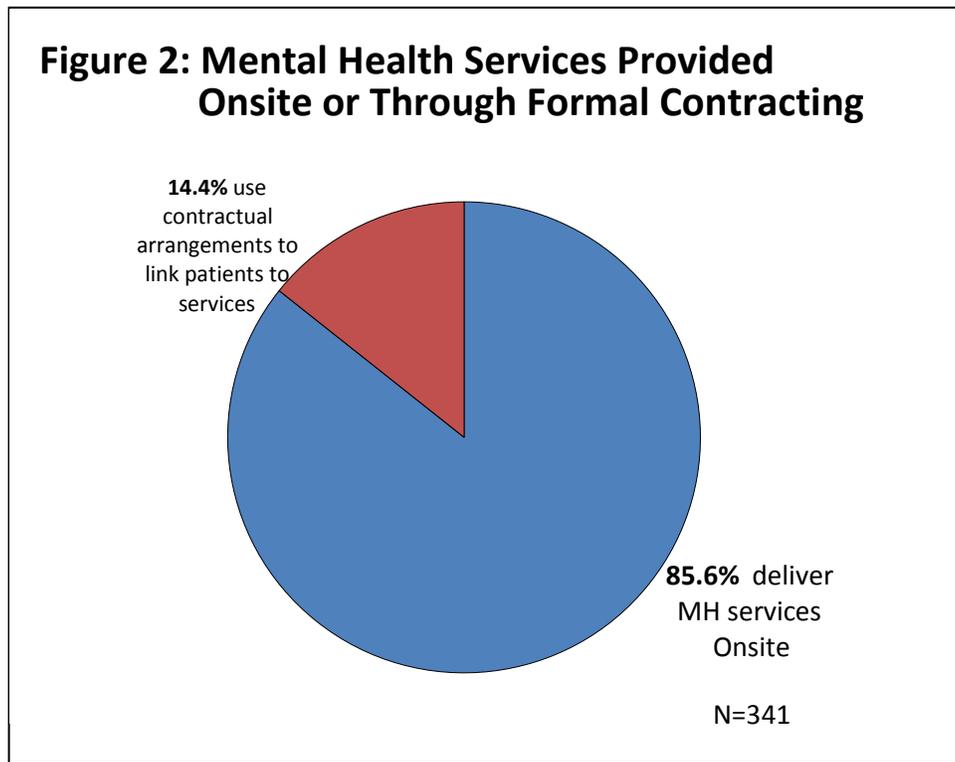
Compared to FQHCs nationally measured by Patient Size 22% of the responding FQHCs fell into the Small FQHC category (under 7,110 patients), 32% in the Medium category (7,110 patients – 16,700 patients) and 46% in the Large FQHC category (over 16,700 patients).



Provision of Behavioral Health Services

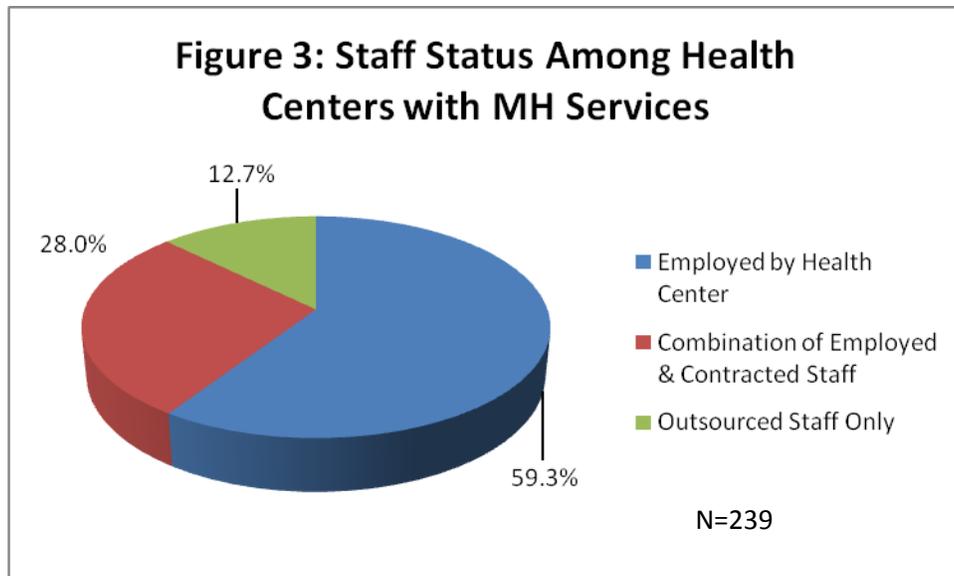
Mental Health Services

Respondents specified whether mental health services are provided onsite or through formal, contractual arrangements. Only one in seven respondents reported the use of contractual arrangements (see Figure 2). The majority, 292 grantees (85.6 percent²), responded that they provide mental health and/or substance abuse services onsite, while 49 (14.4 percent) reported using formal and contractual arrangements to link their patients to mental health services.

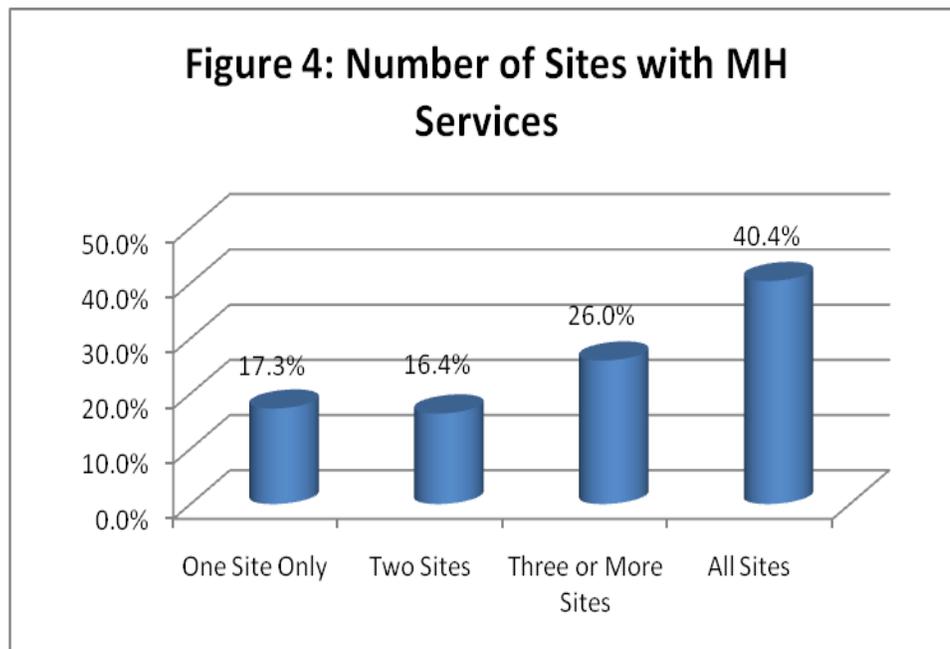


Most FQHCs (59.3 percent, or 201 centers) that provide onsite mental health services only use staff that is employed by the center (see Figure 3). Another 95 FQHCs (28.0 percent) use a combination of staff employed by the center and staff outsourced from another agency. The remaining 43 grantees (12.7 percent) use only staff outsourced from another agency.

² Unless otherwise noted, percentages are of the total number of health centers that answered the question.



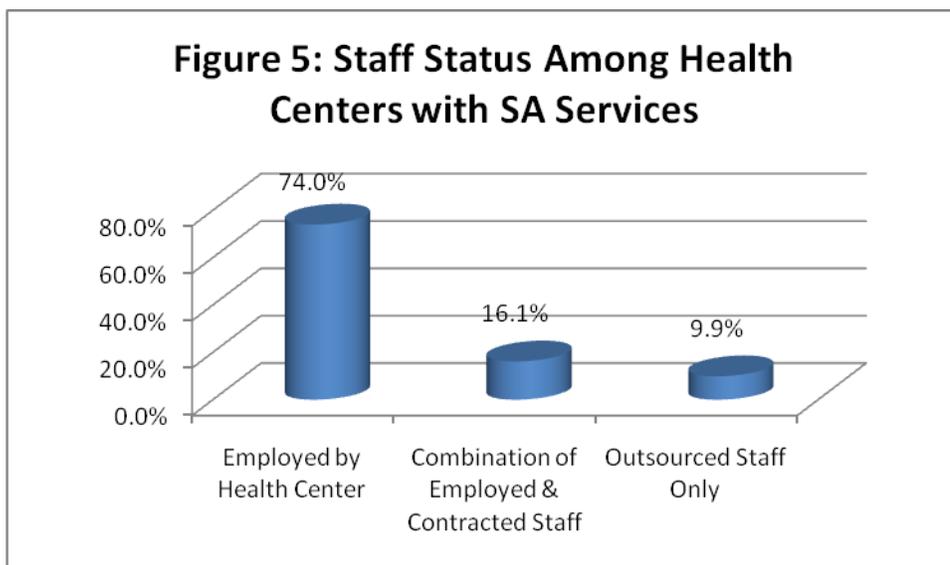
About 60 percent of grantees that do provide mental health services only offer these services in some of their sites while 40 percent provide mental health services in all sites (see Figure 4; this includes onsite services or linkages to formal contractual agreements with outside providers). Of the 342 FQHCs that provide mental health services in at least one site and that specified how many sites offer mental health services, 59 (17.3 percent) provide mental health services in one site only, 56 (16.4 percent) provide mental health services in two sites, 89 grantees (26.0 percent) provide mental health services in three or more sites, and 138 grantees (40.4 percent) provide mental health services in all of their sites.



Substance Abuse Services

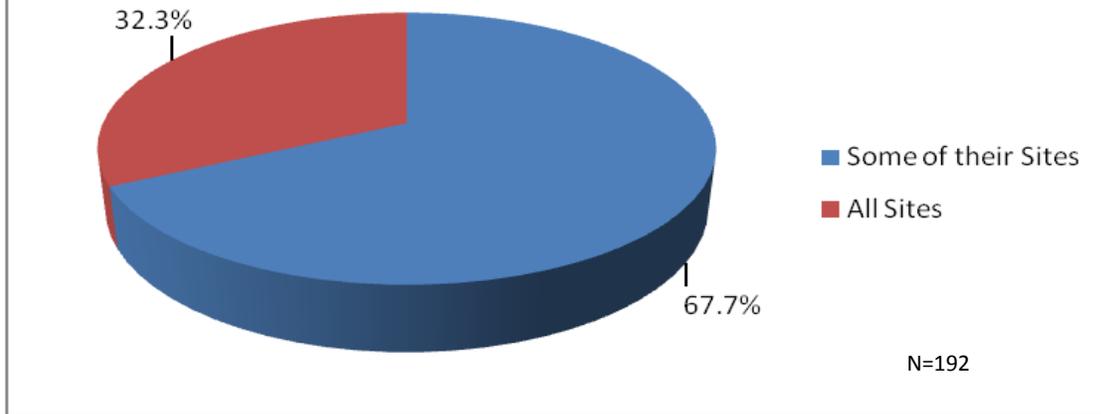
Over half of the 348 respondents (192 respondents, or 55.2 percent) responded that they provide substance abuse services onsite while 113 (32.4 percent) reported using formal and contractual arrangements to provide substance abuse services.

Most FQHCs (73.9 percent, or 142 centers) that provide onsite substance abuse services exclusively use staff that is employed by the center (see Figure 5). Another 31 FQHCs (16.1 percent) use a combination of staff employed by the center and staff outsourced from another agency, while the remaining 19 grantees (9.8 percent) use only staff outsourced from another agency.



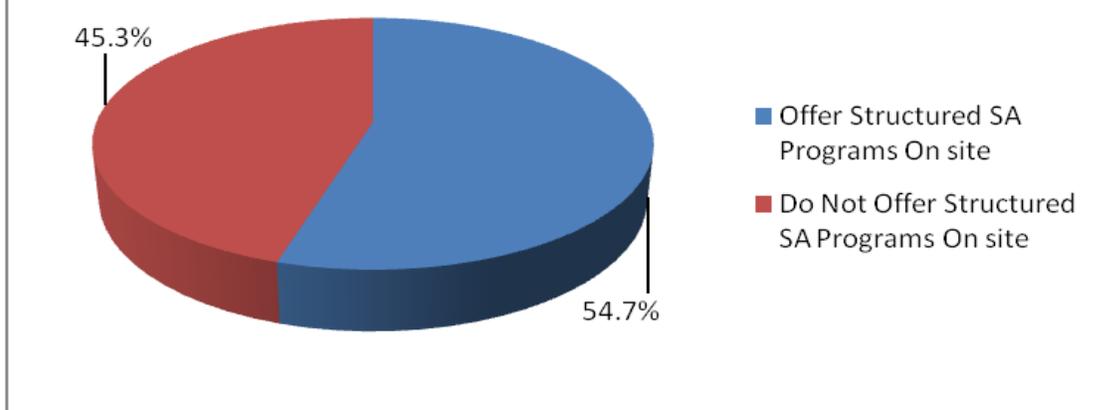
Of the 192 grantees that do provide substance abuse services, 62 (32.3 percent) provide substance abuse treatment services at all of their sites and 130 (67.7 percent) only offer substance abuse services at only some of their sites (see Figure 6). Of the grantees that provide substance abuse service at only some sites and specified the number of sites, 61 (46.9 percent) have substance abuse services at one location, 32 grantees (24.6 percent) provide substance abuse treatment at two locations, and 37 (28.5 percent) offer substance abuse services at three or more locations.

Figure 6: Substance Abuse Service Provision by Sites



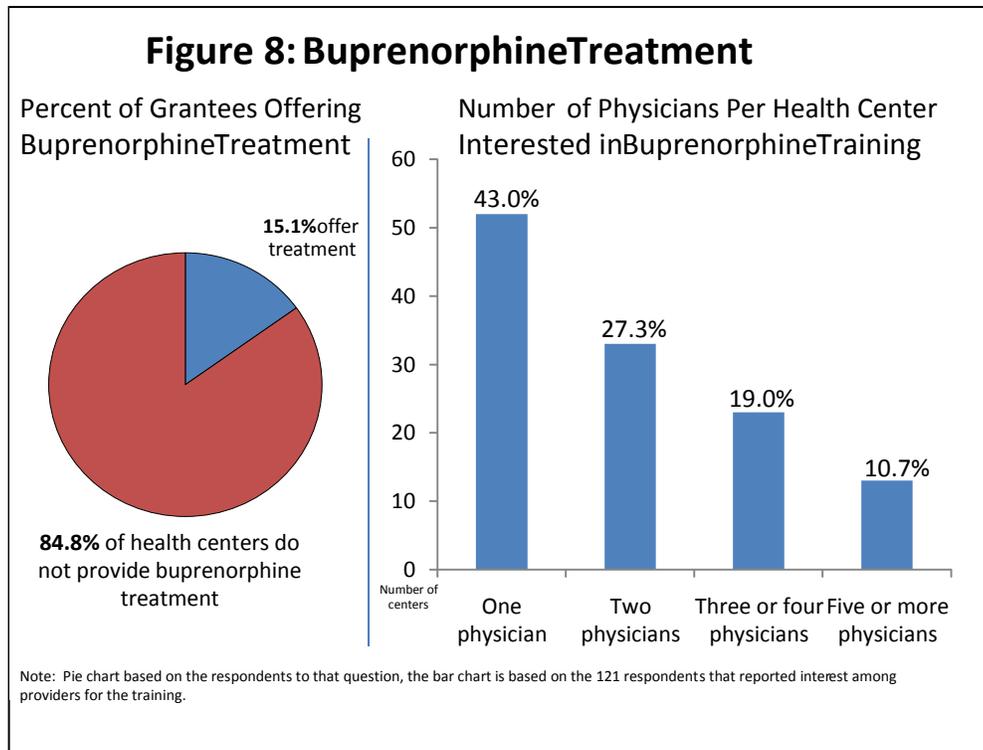
Out of the 192 grantees that do provide substance abuse services, over half (105 centers, or 54.7 percent) offer structured substance abuse treatment programs onsite, while 87 (45.3 percent) report that they do not offer a structured substance abuse program onsite. (see Figure 7). A structured program was defined as: patients seen in individual and/or group sessions on a regularly scheduled basis to address their substance abuse issues. Unstructured programs would allow patients to show up as needed or in conjunction with their medical visits and not provide interventions at regularly scheduled times.

Figure 7: On Site Structured Substance Abuse Programs



Medically Assisted Opiate Abuse Treatment

Buprenorphine treatment for opiate abuse is offered by only 51 respondents (15.1 percent of those that responded to the question), but 121 grantees reported that physicians at their FQHCs would be interested in a free eight-hour course that would help them gain DEA certification to prescribe buprenorphine (see Figure 8). This indicates that an increasing number of FQHCs are likely to offer the service in the future, since FQHCs appear to be interested in expanding capacity in this area.



Of the FQHCs with staff interested in training that would lead to DEA approval to prescribe buprenorphine, over 70 percent estimated that only one or two physicians at their center would be interested in the training. Almost half the respondents (52 or 3.0 percent) stated that only one physician would be interested, while 33 grantees (27.3 percent) estimated that two providers would be interested in training. The remaining third of centers estimate that three or more physicians would be interested in training that would enable them to prescribe buprenorphine.

Staffing

Provider Types

FQHCs reported employing a total of 2582.52 FTE behavioral health care providers (See Table 1). Almost one in three (31.0 percent) of these are licensed social workers.

Table 1: Behavioral Health Specialist Staffing by Provider Type

Provider Type	Total # FTEs	% of Total FTEs	Mean #FTEs per Grantee	# CHCs with FTEs:					Max # FTEs per Grantee	Median #FTEs per Grantee	Total # CHCs
				<1	1-1.9	2-2.9	3-4.9	5 and over			
Social Workers	801.36	31.0	3.22	29	76	47	46	51	63	2	249
Other BH	555.61	21.5	4.87	14	36	20	18	26	83	2	114
Prof. Counselors	262.08	10.1	2.17	19	52	19	17	14	14	1	121
Other Masters Level	238.55	9.2	3.02	8	36	13	8	14	41	1	79
Psychologists	223.18	8.6	1.99	21	60	14	9	8	40	1	112
Psychiatrists	177.58	6.9	1.18	71	43	20	11	5	13	1	150
Addiction Counselors	160.13	6.2	2.03	11	37	14	9	8	14	1	79
Nurses	96.92	3.8	1.33	24	32	10	3	4	6	1	73
Marriage/Family	67.11	2.6	1.27	9	35	5	3	1	7	1	53

Note: Specific staff types are Licensed Social Workers, Licensed Professional Counselors, Licensed Psychologists, Psychiatrists, CAC or CSAS Certified Addiction Counselors, Masters- Prepared Nurses with a behavioral health specialty, and Licensed Marriage and Family Therapists.

Another third of the reported specialty behavioral health FTEs (30.7 percent) were categorized as “other,” and 70.0 percent of these are “other behavioral health workers,” not specified as “other Masters level” providers. This might mean that the bulk of these other types of behavioral health staff used by FQHCs do not have a masters degree.

Professional counselors comprise only ten percent of the reported FTEs.

Psychologists are found in 112 FQHCs and comprise only 8.6 percent of the total specialty behavioral health FTEs reported.

Psychiatrists are employed by 150 FQHCs and make up 6.9 percent of total specialty behavioral health FTEs. The pattern in the number of FTEs per FQHC employing Psychiatrists is unique and skews very low, compared with the number of FTEs employed of other provider types by the average FQHC. Almost half of grantees with Psychiatrists on staff have less than one full FTE, and of the 71 grantees employing less than one full FTE Psychiatrist, only ten employ above 0.5

FTE, highlighting how low Psychiatrist staffing is in most FQHCs. This indicates that many grantees might use Psychiatrists primarily for medication management and to consult on select cases, not to provide extensive verbal therapy for a large group of patients. It may also point to the shortage of Psychiatrists that are actually available to provide services in primary care settings.

Certified addiction counselors are found in 79 FQHCs and comprise 6.3 percent of the total behavioral health FTEs.

Nurses are used by 73 FQHCs.

Marriage and Family Therapists are found in 53 FQHCs.

FQHCs as Training Sites for Behavioral Health Providers

FQHCs play an important role in training specialty behavioral health providers to care for underserved populations. Respondents indicated that 120 FQHCs serve as training sites for social workers (See Table 2). FQHCs serve as training sites for professional counselors at 47 FQHCs and psychology students at 46 FQHCs. Of the 46 FQHCs that train psychology students only 11 FQHCs report that they are approved by the American Psychological Association. This is significant as it is reported that many APA internships are unfilled due to lack of approved sites every year. FQHCs could fill this gap for training sites.

Table 2: FQHCs Serving as Training Sites for Specialty Behavioral Health Staff, by Provider Type

Provider Type	# FQHCs Serving as Training Sites	% FQHCs Serving as Training Sites
Social Workers	120	34.5%
Prof. Counselors	47	13.5%
Psychologists	46	13.2%
Nurses	27	7.8%
Other	24	6.9%
Addiction Counselors	23	6.6%
Marriage/Family	23	6.6%
Psychiatrists	18	5.2%

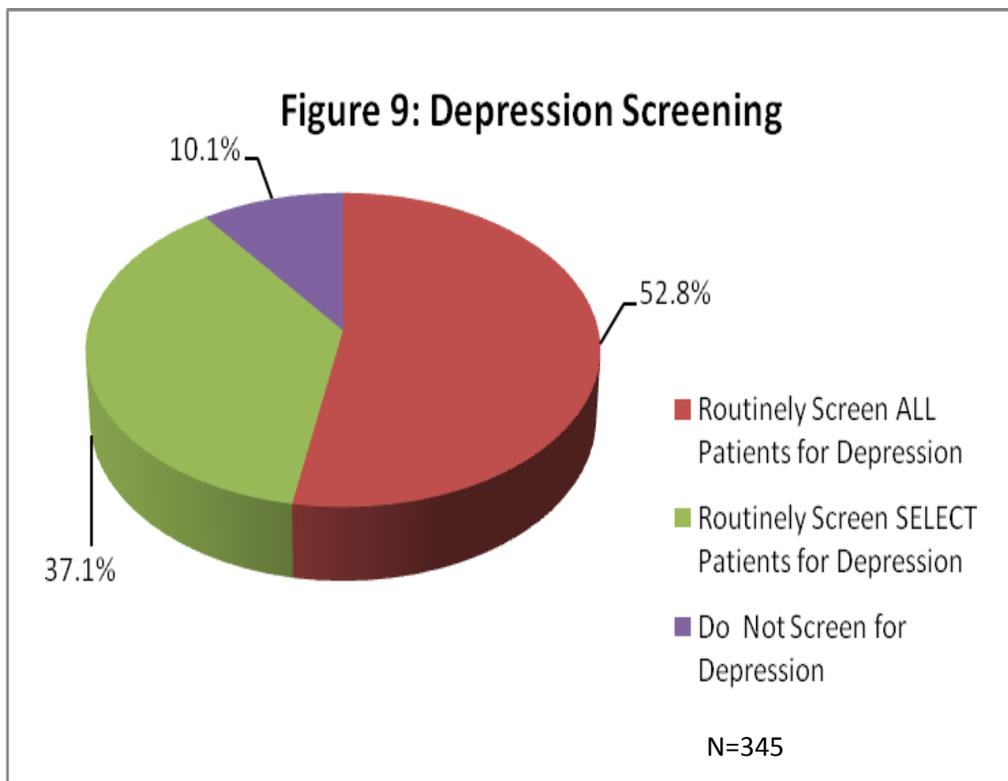
Twenty-seven FQHCs train Masters prepared nurses with behavioral health specialization. Addiction counselors and Marriage and Family Therapists are each trained at 23 FQHCs. Psychiatrists are trained at 18 FQHCs, and 24 grantees train other types of specialty behavioral health providers.

Elements of Integration

Screening Practices and Tools

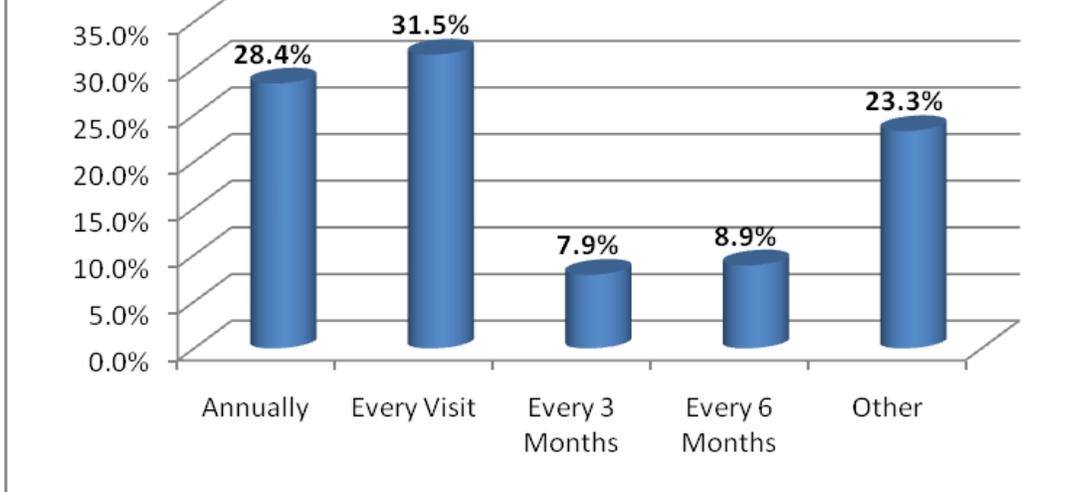
Depression Screening

Depression screening is widely implemented; almost 90% of the FQHCs that responded routinely screen patients for depression (see Figure 9). Of the FQHCs that do screen patients, 128 grantees (37.1 percent) screen a select or targeted group of patients for depression and 182 (52.8 percent) screen all patients. Only 35 FQHCs (10.1 percent of the respondents to this question) report that patients are not routinely screened for depression.



Routine depression screening is implemented either annually or at every visit in most FQHCs (see Figure 10). Screening is done annually in 90 FQHCs (28.4 percent), at every visit in 100 FQHCs (31.5 percent), every three months in 25 FQHCs (7.9 percent), and every six months in 28 FQHCs (8.8 percent), and at other intervals in 74 FQHCs.

Figure 10: Frequency of Routine Depression Screening



Many of the FQHCs that screen a select group of patients for depression administer screening to those with chronic illness, and 25 centers specifically mentioned that they screen patients with diabetes (see Table 3). Other groups were mentioned, such as pregnant and post partum women, adolescents, the elderly, and homeless individuals. Not surprisingly, patients with symptoms or prior behavioral health diagnosis were often targeted for screening. One grantee reported screening all patients, but at only two sites.

Table 3: Target Groups for Routine Depression Screening

Target Group for Depression Screening	# of FQHCs Screening This Group	% of FQHCs Screening This Group
Patients with chronic illness	57	26.0%
Patients with BH symptoms or diagnosis	49	22.3%
Pregnant/postpartum	34	15.5%
Patients with Diabetes	25	11.4%
Adolescents	16	7.3%
Elderly	11	5.0%
HIV/AIDS patients	11	5.0%
Chronic pain patients	7	3.1%
Homeless	5	2.3%
Patients with SA issues	3	1.3%
Veterans	1	0.5%

The responses above are grouped according to self report of the respondents and recognizes that patients with diabetes for example may also be included in the other categories.

Most grantees utilize standardized depression screening tools, following the tradition of evidence-based medicine in the chronic care model. Over four in five FQHCs (282 grantees or 82.7 percent) reported that they use a standardized tool, while 59 grantees (17.3 percent) reported that they do not use a standardized screening tool for depression screening.

The majority of respondents use the PHQ2/9 screening tool (see Table 4). The Beck Depression Scale is also popular, used by 58 FQHCs. Two grantees reported that they developed their own screening tools (they are not included in the group reporting use of standardized screening tools).

Table 4: Standardized Depression Screening Tools

Standardized Depression Screening Tool	# FQHCs Using Tool	% FQHCs Using Tool
PHQ2/9	226	65%
Beck Depression Scale	58	17%
MDQ	18	5%
Other	59	17%

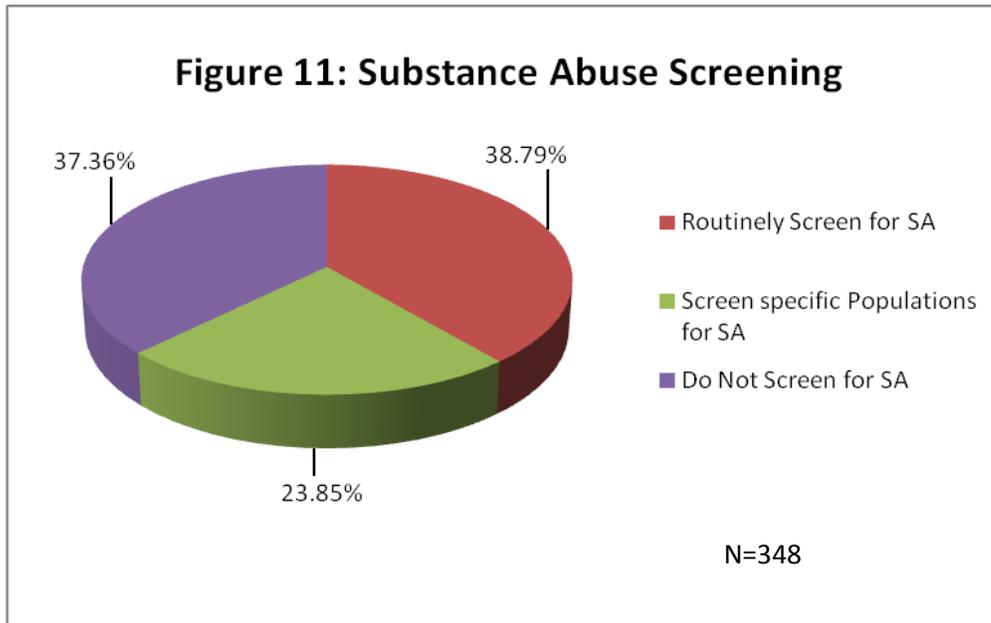
Respondents also listed other screening tools (see Table 5), most often the Edinburgh DI which is specifically targeted towards the needs and symptoms of pregnant and post partum women.

Table 5: Other Screening Tools

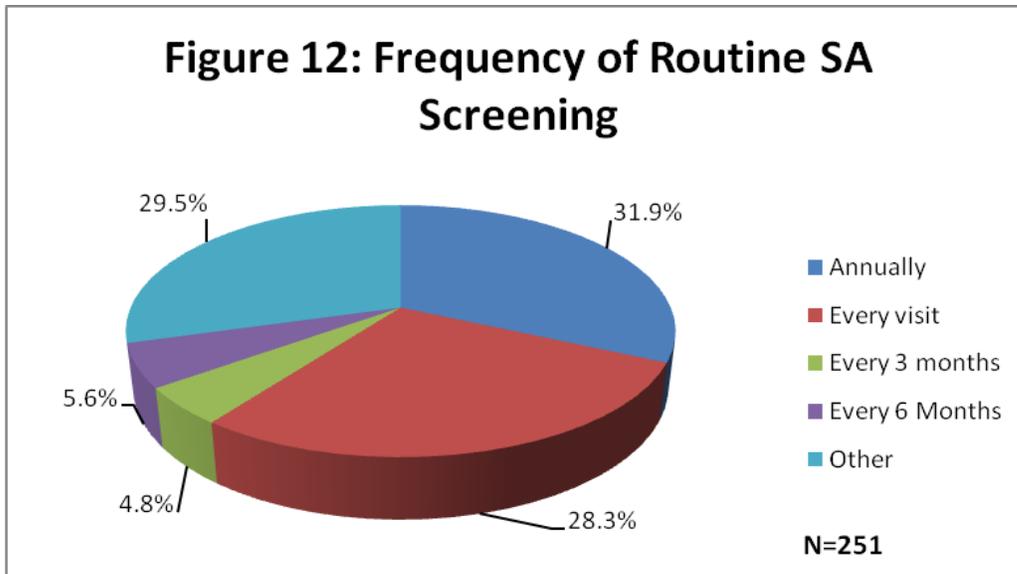
"Other" Depression Screening Tool	# of FQHCs Using this Tool
Edinburgh DI	6
The HANDS Depression Screening Tool	2
CESD	1
Conners Scale	1
DASS 21	1
DSM IV	1
EPDS	1
GAD2	1
Harvard K-6	1
HEADS	1
OQ	1
QPD evaluation panel	1
SAMSISS	1
Shedler QPD	1
WHO-5	1
Zung Depression Self-Rating Scale	1

Substance Abuse Screening

Substance abuse screening occurs on a regular basis in 218 (62.6%) of the FQHCs that responded. (38.8 percent, 135 respondents that provide MH/SA services routinely screen all patients for substance abuse disorders (see Figure 11). 83 (23.8 percent) screen a select group of patients. The other 130 FQHCs (37.4 percent) report that they do not routinely screen patients for substance abuse disorders.



Like depression screening, routine substance abuse screening is most often provided annually or at every visit. Routine screening is implemented annually in 31.9 percent of respondents (80 FQHCs), at every visit in 71 FQHCs (28.3 percent), every three months in 12 FQHCs (4.8 percent), and every six months in 14 FQHCs (5.6 percent), and at other intervals in 74 FQHCs). 26 FQHCs specified that they screen all new patients.



Targeted Screening

FQHCs target different groups of patients for substance abuse screening, and some centers target several subpopulations. Those with behavioral health and/or substance abuse histories or symptoms were most often cited as the group of patients screened for substance abuse disorders. Other groups screened include pregnant women, HIV/AIDS patients, pain patients, adolescents, and the homeless. One respondent reported that they screen all patients in five of their sites.

Table 6: Target Groups for Routine Substance Abuse Screening

Patients Targeted for Substance Abuse Screening	# FQHCs Targeting this Group	% FQHCs Targeting this Group
Patients Treated for BH	20	25.9%
History of Substance Abuse/ Current Symptoms or Signs	15	19.4%
Pregnant women	11	14.2%
HIV/AIDS patients	10	12.9%
Patients with chronic pain	8	10.3%
Adolescents	8	10.3%
Homeless	5	6.4%

Screening Tools

Most FQHCs that use standardized substance abuse screening tools use the CAGE, which is cited almost four times as frequently as the next runner-up, the AUDIT.

Table 7: Standardized Substance Abuse Screening Tools

Standardized Substance Abuse Screening Tool	# FQHCs Using	% FQHCs Using
CAGE	85	44.5%
Other	69	36.1%
AUDIT	23	12.0%
Mini SSI	8	4.1%
ASSIST	6	3.1%

Twelve FQHCs reported that they had developed a substance abuse screening tool, sometimes with elements of other available tools.

Table 8: Other Substance Abuse Screening Tools

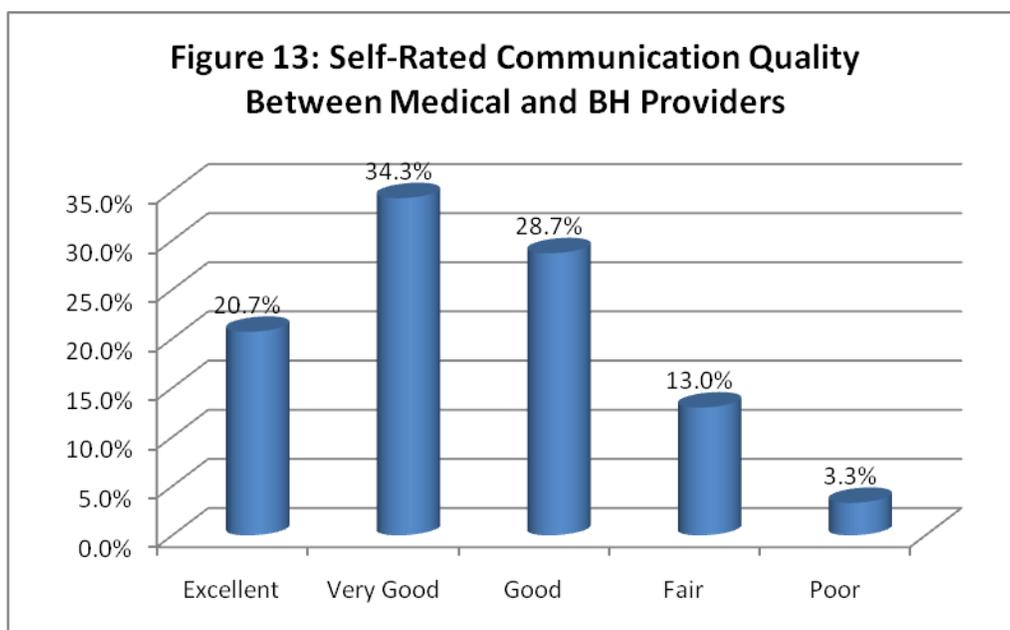
“Other” Substance Abuse Screening Tool	# FQHCs Using
Novel instruments formulated by FQHC	12
SASSI	7
SBIRT	6
Addiction Severity Index	5
GAIN ss	5
DAST	4
CAST/MAST	4
CRAFFT	4
AC-OK	3
SOCRATES	2
ASAM	1
CIAC Comprehensive Intake Assessment Instrument	1
MSSI-SA	1
AWARE	1
Staying Healthy Assessment	1
Wisconsin Uniform Placement Criteria	1

Provider-to-Provider Communication

This assessment explores the specific elements of integrated care with a focus on collaboration and communication with questions probing how often providers meet to discuss mental health and substance abuse cases, who has input into decision making regarding treatment plans, and

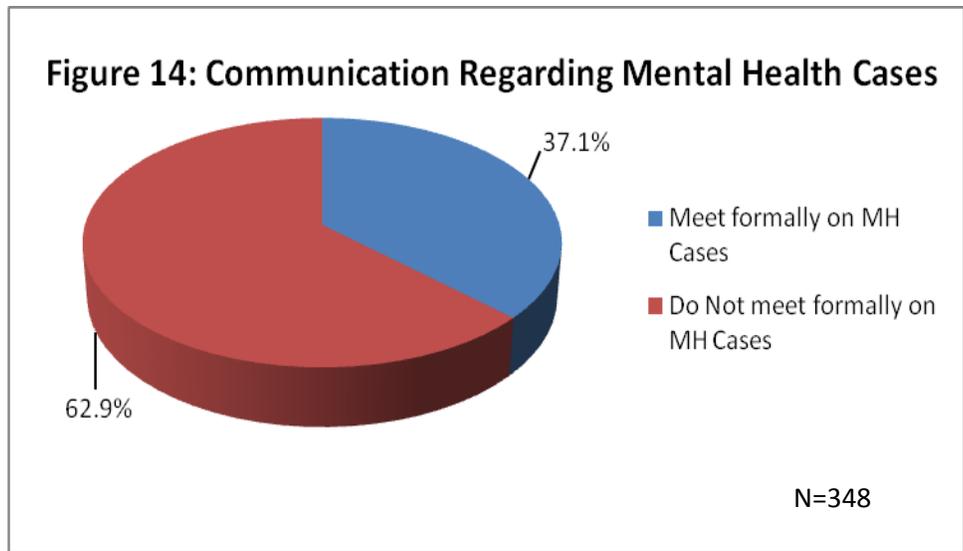
who has access to specific types of information in the patient’s chart or electronic health record (EHR).

Grantees are asked to rate how well medical and behavioral health staff communicate and coordinate their efforts on a Likert scale from poor to excellent, and the majority rated their providers as successfully communicating with each other (see Figure 13). Of the 338 grantees that answered the question, the majority reported excellent or very good communication. One in five grantees (20.7 percent) rated the communication between providers as excellent and 116 FQHCs (34.3 percent) characterized it as very good. Only about one in seven (16.3 percent) rated the communication as fair or poor.



Communication Regarding Mental Health Cases

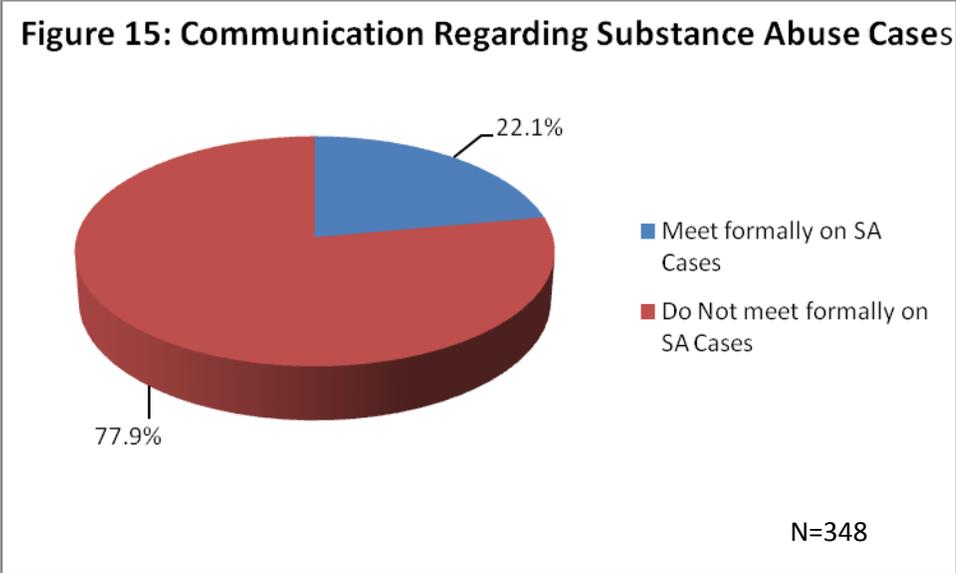
Respondents specified whether and how often medical and behavioral health providers meet to discuss mental health cases. The majority of the respondents, 219 grantees, indicated that their providers do not meet formally about mental health cases. Of these centers without formal meetings, a total of 104 FQHCs report that their providers ***meet informally, only on an as-needed basis.***



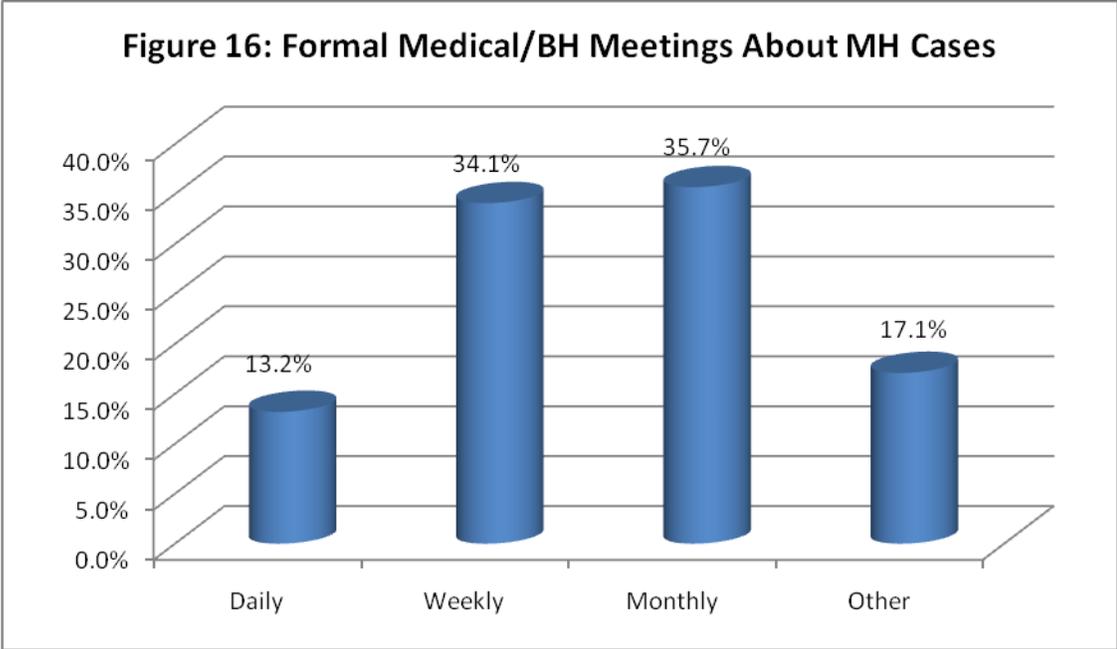
A total of 129 grantees report that their providers do meet formally to discuss mental health cases, and most grantees (69.8 percent) report weekly or monthly meetings (see Figure 14). Of the FQHCs reporting the frequency of formal staff meetings, 17 (13.2 percent) establish daily meetings, 44 (34.1 percent) have weekly meetings, 46 (35.7 percent) have monthly meetings, and 22 (17.1 percent) hold staff meetings at other intervals to discuss mental health cases. Five of the FQHCs that hold staff meetings at other intervals hold biweekly meetings, and one respondent reported that their medical and mental health staff are able to communicate electronically.

Communication Regarding Substance Abuse Cases

77 grantees report that medical staff meets regularly with substance abuse staff to discuss substance abuse cases. The majority of the respondents, 261 FQHCs, report that their medical and behavioral health staff do not meet regularly to discuss substance abuse cases (41 affirmative answers were recoded since they then indicated that meetings occur on an informal basis). (see Figure 15). A total of 72 centers report that staff *meet informally, only on an as-needed basis*.



Of the FQHCs reporting the frequency of formal staff meetings, 14 (18.2 percent) establish daily meetings, 27 (35.1 percent) have weekly meetings, 27 (35.1 percent) have monthly meetings, and 13 (16.9 percent) hold staff meetings at other intervals to discuss mental health cases (see Figure 16). Three of the FQHCs that reported other frequencies for formal meetings hold meetings twice per month, and one FQHC reported provider-to-provider communication occurring by phone and computer.

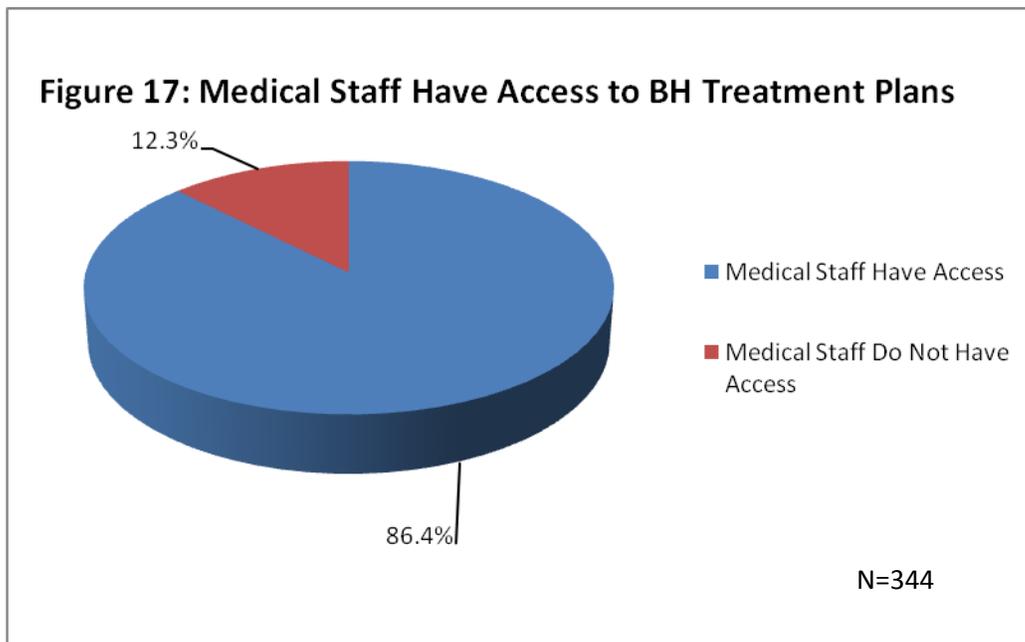


Access to Information in Patient Charts

Behavioral Health Treatment Plans

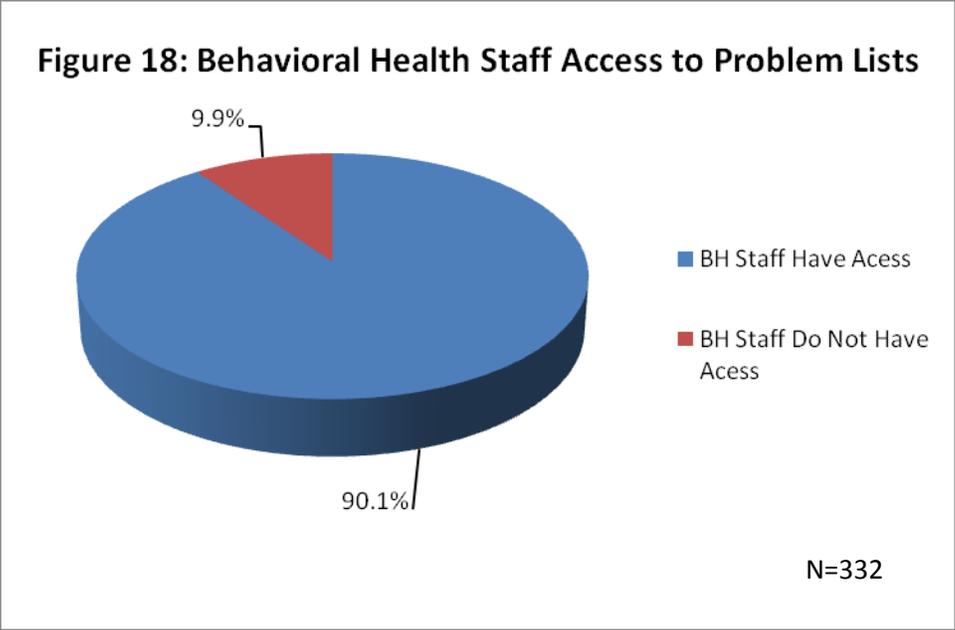
Sharing of information among all treatment providers is an integral component of integrated care. The majority of FQHCs 274 (86.4 percent) indicated that they allow medical staff access to behavioral health treatment plans (see Figure 17). Of the others that answered the question, 39 FQHCs (12.3 percent) report that medical staff do not have access to behavioral health treatment plans and 31 (9.0 percent) FQHCs responded that their patient charts do not include behavioral health treatment plans.

However, in only 62 (17.8 percent) of the FQHCs that responded do both medical and behavioral health providers sign behavioral health treatment plans. The remainder of the respondents identified that medical providers do not sign treatment plans or that they do not complete behavioral health treatment plans. This is not unusual in primary care settings as behavioral health specific treatment plans are mandated in licensed behavioral health settings and are not required in primary care settings.



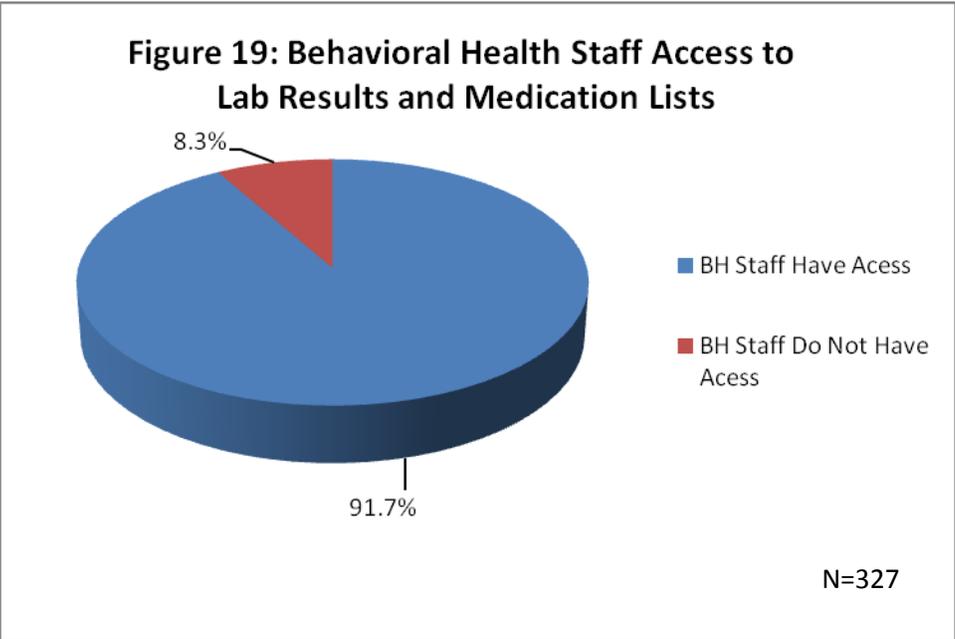
Access to Problem Lists

The majority of FQHCs 299 (90.1 percent) allow behavioral health providers access to Problem Lists. Both types of staff do not have access to Problem Lists in 33 FQHCs (9.9 percent).



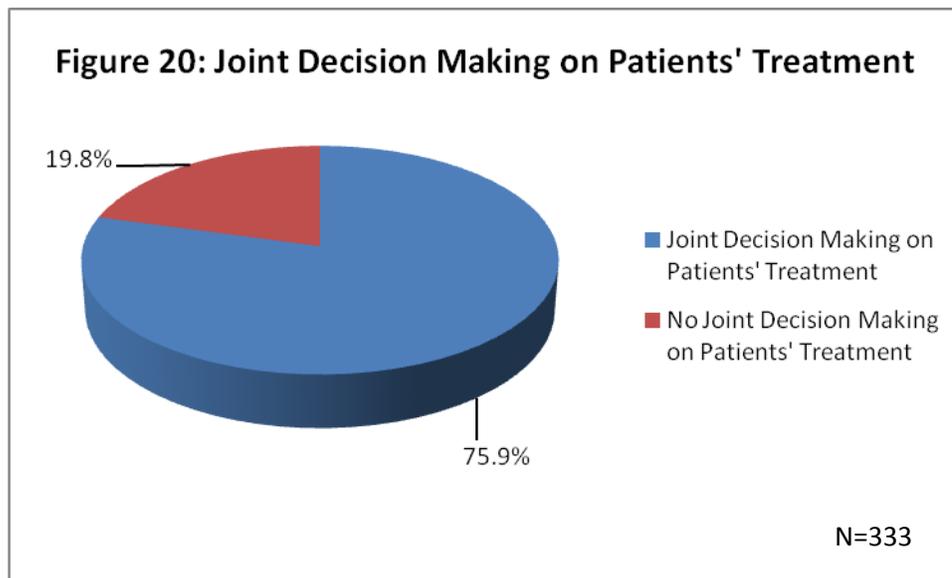
Access to Lab Results and Medication Lists

Both medical and behavioral health staff have access to lab results and medication lists in patient charts in 300 FQHCs (91.7 percent). Both types of staff do not have access to lab results and medication lists in 27 FQHCs (8.3 percent). (see Figure 19)



Decision Making Processes

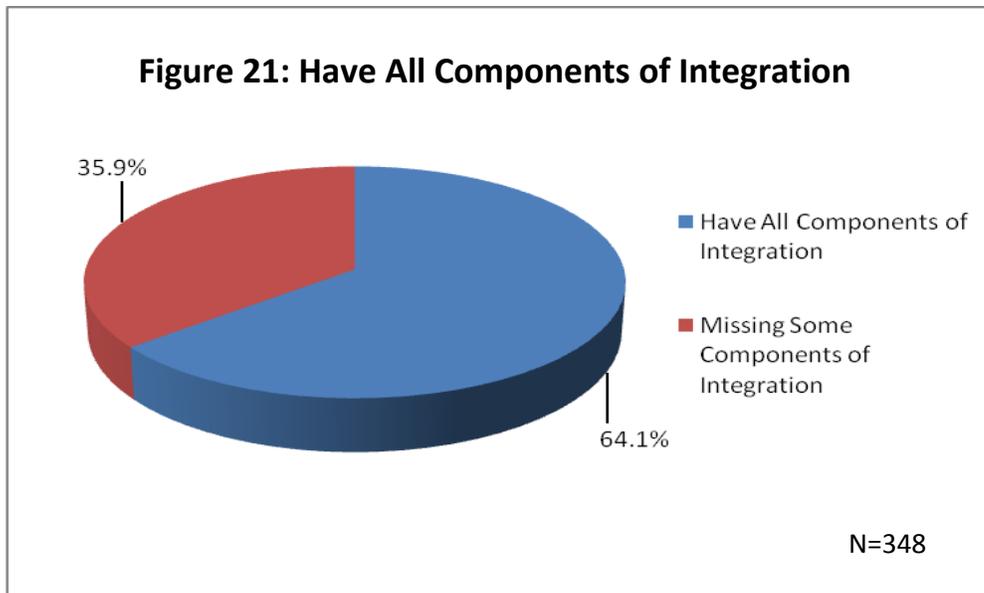
A critical issue is whether both behavioral and medical staff make “joint decisions on the patient’s plan of care.” Joint decision making would entail both the primary care provider and the behavioral health provider having input into and ideally coming to consensus on the plan of care for the patient. The majority, 264 centers (79.3 percent), indicated that both types of staff have decision making authority, while 69 respondents (20.7 percent) indicated that decisions on patient care plans are not made by both types of staff (see Figure 20).



Movement Towards Integration

We found that almost 65% of the FQHCs that responded had all of the components of being fully integrated (see Figure 21) which in addition to Co-Location included having:

- Good Communication and Collaboration between Medical and Behavioral Health Providers
- Sharing Behavioral Health Treatment Plans
- Sharing Problem Lists
- Sharing Lab Results and Medication Lists and
- Joint Decision Making for Patient Care



Training Needs

Respondents chose from a menu of training needs and most grantees chose several, and then highlighted one as the most pressing training need for their staff. Training medical providers about how to treat behavioral health disorders was the strong front runner in most number of mentions and number of times cited as the most pressing need (see Table 9).

Table 9: Training Needs

Type of Training	# CHCs Mention Training Need	% CHCs Mention Training Need	# Cite as Most Pressing Need	% Cite as Most Pressing Need
Training medical providers on BH disorders	187	53.7%	74	21.3%
Short term interventions	149	42.8%	41	11.8%
No shows	142	40.8%	35	7.1%
Problem focused treatment	136	39.1%	17	4.9%
SBIRT	133	38.2%	27	7.8%
Reimbursement/coding	131	37.6%	42	12.1%
Motivational Interviewing	130	37.4%	27	7.8%
PTSD and trauma interventions	112	32.2%	17	4.9%
Compliance	101	29.0%	13	3.7%
Documentation	80	23.0%	7	2.0%
Scheduling	49	14.1%	7	2.0%
Other	40	11.5%	22	6.3%

Training on short term interventions was also cited often as a need; 149 FQHCs highlighted the need and 41 responded that it is the most pressing need. Screening, brief intervention and referral to treatment (SBIRT), was cited by 133 FQHCs as a training need and by 27 as the most pressing need. Training for problem-focused treatment and motivational interviewing, closely related concepts, is also highly in demand; 136 and 130 FQHCs cited training needs in these areas, respectively.

Managing the No Show Rate is a persistent problem in providing behavioral health services, cited by 142 centers as a problem that needs to be addressed with provider training, and 35 FQHCs highlighted No-Shows as the most pressing training need.

Reimbursement and coding was cited as the top priority training need by 42 FQHCs, while 131 total FQHCs pointed to a need for training about reimbursement and coding.

PTSD and trauma interventions are also identified as a high training need.

Table 10: Other Types of Training Needs

Type of "Other" Training Needed	# CHCs Mention Training Need
Improving integration or linkages with BH specialists	12
Psychopharmacology	7
Pain management	4
Improving BH for those with chronic medical conditions	4
State regulations	1
Special populations such as immigrants and refugees	1
Routine screening	1
EMR Training	1
Integrating substance abuse treatment into care	1

Technical Assistance: The Role of NACHC

We also asked FQHCs two questions related to how NACHC could assist them to improve quality care and to improve capacity. The responses to both questions were similar in nature and grouped into three categories. The questions were a) *What is the most important thing NACHC*

could do to assist your health center to improve the quality of behavioral health services? and b) What is the most important thing NACHC could do to assist your health center to increase capacity to meet the behavioral health needs of your patients? In order of frequency of responses they were:

Increased Training

Respondents requested more training in integrating behavioral health in primary care in 37% of their responses. The requests included training on best practices in integrated models, specific assistance for programs that are starting behavioral health programs, educating staff on the importance of joint care management for behavioral health patients, billing and coding issues and how to deal effectively with high No Show Rates. The requests were for low cost webinars, financing for training and also to continue to have these trainings provided at the NACHC national conferences.

Funding

Responses in this category, included increasing funding for behavioral health providers in FQHCs directly, eliminating the barriers to same day billing in Medicaid, eliminating the barriers of MCOs contracting with behavioral health providers in FQHCs and increasing the licensed behavioral health professionals that can provide services in FQHCs and be considered billable providers. Currently most states only approve licensed social workers and licensed psychologists and do not include licensed professional counselors or licensed marriage and family therapists.

Increased Training Targeted to Primary Care Providers

Respondents specifically requested training targeted to the Primary Care Providers in 11% of the responses. The training was requested to be focused on training primary care providers on the need for behavioral health services, train them in treating substance abuse issues, pain management issues and how to coordinate care with their behavioral health colleagues.

Analysis, Implications and Next Steps

Mental Health Services

While over 85% of FQHCs responding provide mental health services on site only 40% provide mental health services at all of their sites.

Recommendation: More targeted investigation will be needed to determine the barriers to providing mental health services at all sites. This may be a workforce issue due to the shortage of behavioral health providers, however, closer collaboration between FQHCs and local behavioral health providers may help to address this issue.

Substance Abuse Services

Nearly half (45.3%) of the FQHCs that responded do not provide substance abuse services on site. Only 45.3% of the centers that responded and do provide substance abuse services provide “structured substance abuse services”.

Recommendation: More targeted investigation will be needed to determine the barriers to providing substance abuse services at all FQHCs and at all sites. FQHCs may also need additional training to implement “structured” programs and will also need to develop relationships with local substance abuse providers to build this capacity.

Medically Assisted Treatment for Opiate Abuse Treatment

Only 15% of the FQHCs that responded provide buprenorphine treatment for opiate abuse, however, 121 grantees (34.7%) identified that providers at their FQHC would be interested in attending the DEA required eight hour course to obtain the training necessary to prescribe buprenorphine.

Recommendation: NACHC will continue to work with SAMHSA/HRSA and other partners to bring buprenorphine training to FQHCs nationally to expand this much needed service.

Staffing

The highest percentage of behavioral health providers in FQHCs are Licensed Social Workers (31.0%) followed by Other Behavioral Health Providers (21.5%) and then Professional Counselors (10.1%)

Most state Medicaid programs only allow Licensed Social Workers and Licensed Psychologists to provide and bill for behavioral health services in FQHCs. The lack of Licensed Psychologists providing services in FQHCs is an area of concern that may be addressed with the American Psychological Association and their Training Directorate. Currently an APA accredited internship program requires a licensed APA accredited psychologist to be on site which makes it very difficult for psychologists to receive training in a FQHC environment due to the current scarcity of psychologists in FQHCs.

Recommendation: Policy discussions should consider whether other licensed providers should be eligible billable providers in FQHC settings. This would increase the behavioral health provider workforce.

Approximately 43% of the FQHCs that responded employed psychiatrists, however, almost half of these have less than a full time psychiatrist.

Recommendation: Telemental health services are appropriate for psychiatric and behavioral health treatment and should be expanded in FQHC environments. Billing for the services needs to be assured under the state Medicaid plans which differ from state to state.

FQHCs as Training Sites for Behavioral Health Providers

FQHCs serve as training sites for all behavioral health providers, however, social workers are the predominant provider type trained at 34.5%.

Recommendation: A concerted effort should be made to advocate that more FQHCs serve as training sites for other behavioral health providers.

Integration of Behavioral Health

Depression Screening

Over 90% of FQHCs that responded routinely screen patients for depression. 52% screen all patient and 37% screen a select or targeted group of patients. Those that do screen a targeted or select group of patients are targeting groups with high incidence of co morbid disorders.

FQHCs for the most part (87%) are using evidence based tools to conduct depression screening. The most frequently used tool is the PHQ2/9 (67%) followed by the Beck Depression Scale (17%).

Recommendation: Continue to provide education to FQHC providers in the adoption of new evidence based tools that will screen out depression but also be sensitive to screen for bi polar disorder and anxiety disorders.

Substance Abuse Screening

Almost 40% of the FQHCs that responded screen all patients for substance abuse and 24% screen a select group of patients. Almost 40% of FQHCs do not screen for substance abuse. It is only provided at every visit or at least every three months in only 32% of the FQHCs that responded. When screening is conducted most FQHCs are utilizing evidenced based tools, however, some are not.

Recommendation: Due to the wide disparity in substance abuse screening versus depression screening a concerted effort should be made to increase the use and frequency of substance abuse screening by FQHCs. Education to FQHCs regarding evidenced based tools would also be helpful. There are a number of evidenced based tools that could be utilized, however, some are less specific for substance abuse disorders or for

“risky” behaviors than others. The CAGE for example utilized by many FQHCs is not as specific as the AUDIT-C for “risk” of substance use.

Provider-to-Provider Communication

Communication among behavioral health and medical providers in FQHCs seems to be very good. Over 50% of the FQHCs rated the communication as either Very Good or Excellent and only 16% rated it as Fair or Poor.

Most FQHCs do not meet formally to discuss mental health cases. Of those that do meet formally almost 70% have weekly or monthly meetings.

With regard to substance abuse cases the staff meet even less frequently. Only 22% of the FQHCs identified that they meet formally to discuss substance abuse cases.

Recommendation: Although Provider-to-Provider Communications are reported as good at FQHCs more focus may be needed on the use of formal meetings to address difficult patients especially those with co occurring mental health and substance abuse disorders.

Access to Information in Patients Charts

Access to Behavioral Health Treatment Plans

Of those FQHCs that provide behavioral health services most allow medical providers access to behavioral health treatment plans. Only 12% of the responding FQHCs did not allow access.

Recommendation: There is often confusion regarding HIPAA and 42 CFR Part 2 regulations and what is allowed to be shared among treating providers and more education may be required to clarify misconceptions regarding HIPAA and 42 CFR Part 2 rules and sharing of behavioral health information among treating providers.

Access to Problem Lists

Of those FQHCs that provide behavioral health services most (90%) allow behavioral health providers access to Problem Lists. Only 10% do not.

Recommendation: As with behavioral health treatment plans more education may be required on allowing all treatment providers access to the patient record including behavioral health providers access to Problem Lists.

Access to Lab Results and Medication Lists

Of those FQHCs that provide behavioral health services most (90%) allow behavioral health providers access to Lab Results and Medication Lists.

Joint Decision Making on Patients' Treatment

Almost 80% of the FQHCs identified that there is joint decision making on patients' treatment by behavioral health and medical providers while 20% identified that there is not.

Recommendation: Additional training is be required to build staff cohesiveness and systems that will allow and encourage joint decision making. This activity will be integrated with NACHC Patient Centered Medical Home initiatives.

Movement Towards Integration

We found that almost 65% of the FQHCs that responded had all of the components of being fully integrated which included having:

- Good Communication and Collaboration between Medical and Behavioral Health Providers
- Sharing Behavioral Health Treatment Plans
- Sharing Problem Lists
- Sharing Lab Results and Medication Lists and
- Joint Decision Making for Patient Care.

Training Needs

The training Needs most frequently identified by FQHCs that responded to the assessment include:

- Training medical providers in treating behavioral health disorders
- Short Term Interventions
- Decreasing No Show Rates
- Problem focused treatment
- SBIRT (Screening Brief Intervention and Referral to Treatment)
- Motivational Interviewing
- Reimbursement and coding was also a training request

NACHC will utilize the data from this assessment to develop additional programs to meet the needs of FQHCs nationally. FQHCs that have been identified as leaders in collaboration will be called upon to assist in training other FQHCs in the future.