Welcome to the Kansas Integrated Care Learning Network Kick Off

9/17/2025

Agenda for the Morning

- Overview and timeline of Farley Health Policy Center work with the Kansas Integrated Care Network
- Introduce HealthTeamWorks and opportunities for practice support
- Overview of the Building Blocks for Behavioral Health Integration (BBBHI) Framework
- Introduce BBBHI eLearning Module

- Policy insights to advance behavioral health care in Kansas
- Small group deep dive into policy insights
- Prioritizing next steps

The Farley Center strives to bridge the gap between research and policy.

- Study policy to expand knowledge and investigate issues to improve health systems
- Partner with researchers to translate findings and outcomes that inform action and policy change
- Educate the next generation of policy and advocacy-focused health professionals
- Provide decision makers high-quality evidence to develop more equitable systems and policies
- Convene diverse and inclusive cohorts to identify policy levers for shared solutions
- Make policies actionable by supporting effective implementation

How did we get here?

2023

Learning Network/Planning Year with Health Innovations Network of Kansas (HINK)

2024

Implementation Year with HINK

Planning Year Sunflower Health Network

2025

Exploring policy solutions to integrate behavioral health in Kansas

Kansas Integrated Care Learning Network

What's Next for the Kansas Integrated Care Network?

Monthly Learning Community Calls

October 2025 – March 2026

Third Friday of every month

12:00-1:00 CT

Registration coming soon.

Learning Network content will be focused on a deep dive into Foundational Care Delivery Expectations from the BBBHI Framework

HealthTeamWorks: Mission, Impact & Services

We team to transform health care with responsive solutions that drive high-quality and strengthen communities.

- Performance Improvement
- Organization Development
- Training Programs

HealthTeamWorks®

HealthTeamWorks: Integrated Care Network

- April – September 2026
- Maximize your time investment
- Provide the right support at the right time.
- Foster peer-to-peer learning.
- Capture and share best practices.

Virtual Affinity Groups

Virtual 1-on-1 Sessions

In-Person Regional Sessions

HealthTeamWorks®

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Questions?

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Practice Innovation Program
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WELL BEING TRUST

The Building Blocks of Behavioral Health Integration

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Acknowledgments: CJ Peek, key informant interviewees, PCC BHI Workgroup

Outline

- Rationale
- Framework development
- Framework components
- Application to payment
- Next steps

…the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Why create Building Blocks of BHI?

- Behavioral health needs are common
- Primary care and behavioral health are inseparable
- Integrating behavioral health and primary care is effective*
- Current payment mechanisms limit the expansion of behavioral health integration
- Payers want demonstrated accountability to standardized care delivery expectations

Behavioral health integration improves outcomes

STUDIES SHOW:

Over half of patients with a PHQ-9 score of ≥10 at baseline had a reduction of **≥ 5-points after receiving integrated care,** a clinically meaningful improvement.[1]

Youth had a 66% probability of having a better behavioral health outcome if they received integrated care.[2]

Adults with depression were **31% more likely** / Adults with anxiety were **41% more likely**

to have improved outcomes with collaborative care in comparison to usual care[3]

1. Balasubramanian BA, Cohen DJ, Jetelina KK, Dickinson LM, Davis M, Gunn R, Gowen K, Miller BF, Green LA. Outcomes of Integrated Behavioral Health with Primary Care. The Journal of the American Board of Family Medicine. 2017 Mar 1;30(2):130-9.
2. Asarnow JR, Rozenman M, Wiblin J, Zeltzer L. Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis. JAMA Pediatr. 2015;169(10):929-937.
3. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews. 2012;10.

Behavioral health integration saves money

STUDIES SHOW:

Cost savings of 5%-10%
for patients receiving collaborative care
over a 2-4 year period.[1]

Estimated $860 per member per year cost savings
for patients receiving integrated services in one large primary care clinic.[2]

ROI of over $2:1 for investment
in integration in 3 practices after 18 months.[3]

1. Melek SP, Norris DT, Paulus J. Economic impact of integrated medical-behavioral healthcare: Implications for psychiatry. Milliman American Psychiatric Association Report, April 2014.
2. Ross KM, Klein B, Ferro K, McQueeney DA, Gernon R, Miller BF. The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: a prospective, case-control program evaluation. Journal of Clinical Psychology in Medical Settings.2018.
3. Ross KM, Gilchrist EC, Melek S, Gordon P, Ruland S, Miller BF. Cost savings associated with an alternative payment model for integrating behavioral health in primary care. Translational Behavioral Medicine. 2018;9(2):274-281.

There was a lack of a framework independent of a particular model of integrated behavioral health care that is designed to allow for flexibility in approach, operationalizing a differential payment structure, and sets minimum standards for care delivery expectations.

Bipartisan Policy Center Behavioral Health Integration Task Force

Recommendation 1: Establish core service and quality standards to improve accountability for integrating care.

Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration

TASK FORCE RECOMMENDATIONS

March 2021

Bipartisan Policy Center

Grounding Principles

- Behavioral health and primary care services have both been chronically underfunded and traditionally separated in terms of training, delivery, payment, and administration.

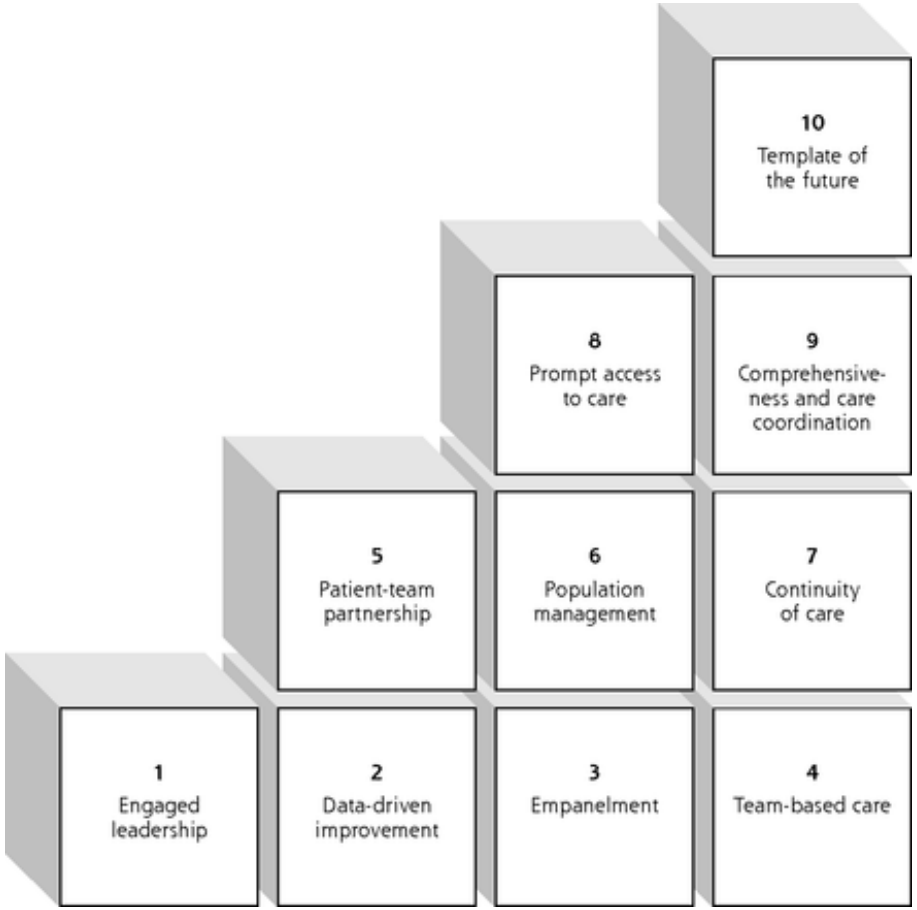
- Integrating behavioral health in primary care is not a small quality improvement project but a transformative undertaking for the entire practice.

- Practices implement integrated behavioral health using a variety of approaches. There is not a single model of integrated behavioral health that will be the right fit for all practices.

- Different approaches to integrated behavioral health will require different levels of resources, including financial support.

Framework Development

- Selection of a nationally recognized organizing scheme
- Development of behavioral health integration milestones for a statewide demonstration project
- Refinement of behavioral health integration milestones and categorization into different implementation approaches
- Review of other frameworks to identify gaps
- Vetting with key informants and further refinement based on feedback



The Building Blocks of Behavioral Health Integration

Components of Behavioral Health Integration

Foundational Care Delivery Expectations: requirements for any practice integrating behavioral health.

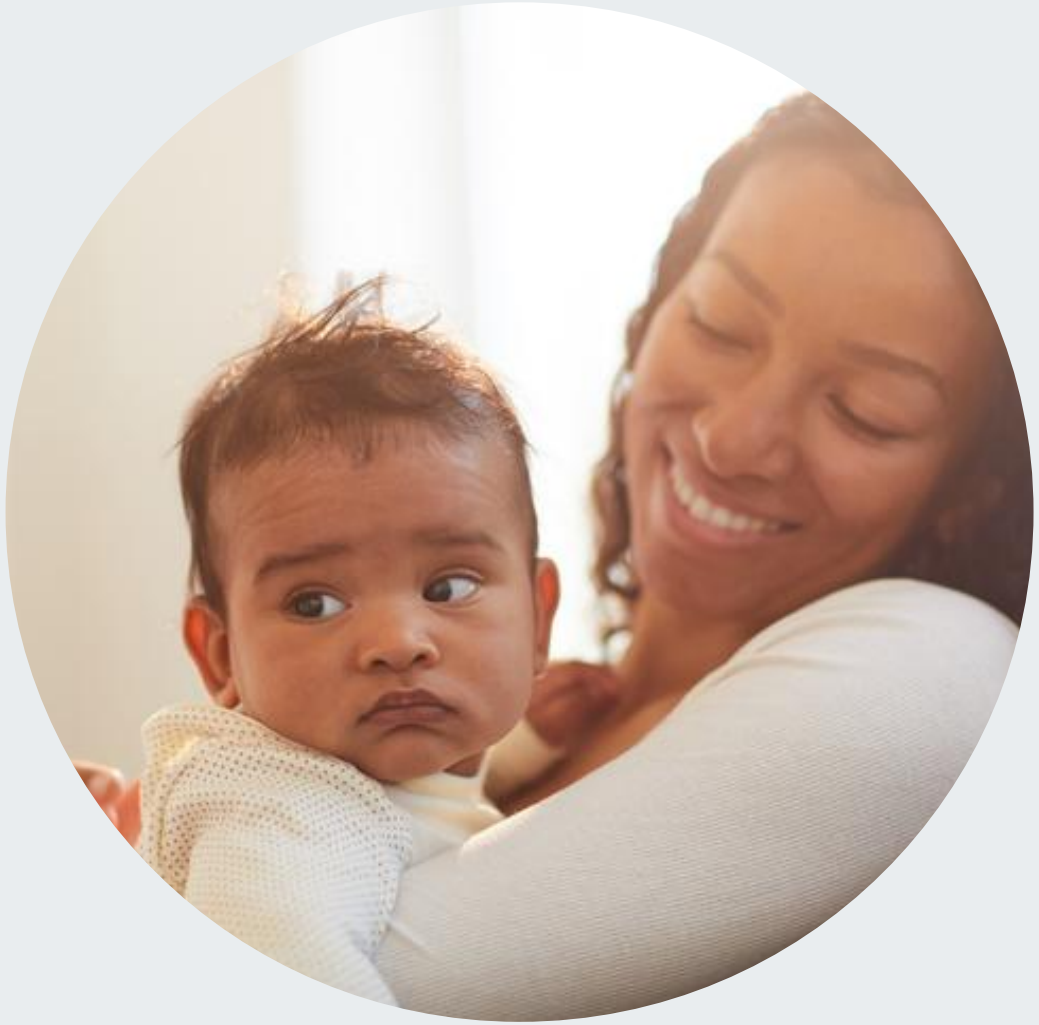
Additional care delivery expectations by components:

- **Advanced Coordination and Care Management**
- **Integrated Behavioral Health Professional**
- **Psychiatry**
- **Advanced Care of Substance Use Disorders**

Components of Behavioral Health Integration

Foundational Care Delivery Expectations:

- Patients who will benefit from services identified through universal screening
- Behavioral health care provided within the practice and/or patients are linked to care
- Follow up tracked for patients referred to outside services
- Measures specific to behavioral health integration are tracked and reviewed regularly



Components of Behavioral Health Integration

Advanced Coordination and Care Management:

- Practice develops shared expectations and exchanges information with behavioral health providers
- Practice manages a registry of patients with target behavioral health condition(s)
- Practice screens for social needs and links patients and families to services

Components of Behavioral Health Integration

Integrated Behavioral Health Professional:

- An integrated behavioral health professional (which could be a psychologist, licensed clinical social worker or other licensed professional) works as part of the primary care team.
- The integrated behavioral health professional provides counseling, diagnostic support, crisis management, and behavior change support in partnership with the primary care provider.
- Services can be provided in person or via telehealth.
- For smaller, independent and/or rural practices, a behavioral health professional may be shared across practice sites.

Components of Behavioral Health Integration

Psychiatry:

- A psychiatrist supports complex diagnostic evaluation and medication management, providing consultation to the primary care provider.
- They may provide direct patient care either in person or via telehealth.

Components of Behavioral Health Integration

Advanced Care of Substance Use Disorders:

- The primary care provider prescribes medication for substance use disorders including tobacco use disorder, alcohol use disorder, and opioid use disorder.
- Counseling related to substance use disorders is provided in the practice or coordinated with resources outside of the practice.

Framework Excerpt

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Leadership	• Practice has defined mission and vision related to meeting behavioral health needs and a defined behavioral health champion or team. • Practice has budget with allocated resources for transformation and quality improvement work related to behavioral health, including behavioral health professional(s) if part of the care team, that incorporates planning for sustainability of services.	*No component-specific expectations.*
Data Driven Quality Improvement	• Practice, including any behavioral health professionals, meets regularly (minimum monthly) to review data and processes for quality improvement including those related to behavioral health efforts. Where available, practice reviews data disaggregated by subpopulations to identify and address disparities. • Practice collects and reports on measures specific to behavioral health efforts and tracks performance relative to targets. This includes tracking reach (level 1–proportion of target population screened; level 2–proportion of positive screens that are addressed) and outcomes with validated measures such as the PHQ-9, GAD-7, and Edinburgh maternal depression scale. In practices caring for children, this includes developmental screening. • Practice collects and reports on holistic patient-reported measures of experience of care, access to care, and/or patient-reported functioning or quality of life.	• **Advanced Coordination and Care Management**—Includes tracking rates of follow up after behavioral health related emergency department visits or hospitalizations. • **Integrated Behavioral Health Professional**—Includes tracking adequate FTE and availability of appointments with behavioral health provider. • **Psychiatry**—Includes tracking adequate FTE and availability of consultation with psychiatrist. • **Advanced Care of Substance Use Disorders**—Includes tracking of outcomes related to patient initiation and engagement in substance use disorder treatment and follow up after substance use disorder-related hospitalizations.

How this framework is different

1. Components of different approaches to integrated behavioral health are separated so that:
   - Practices can flexibly choose their approach
   - Levels of financial support can be designed to match the selected approach
2. Not specific to a certain model of behavioral health integration
3. Not particular to a specific behavioral health diagnosis, reflects the wide spectrum of behavioral health services that can be provided in primary care
4. A core set of foundational expectations are established
5. Driven by practice-based evidence and experience and refined through input from key informants of diverse roles and backgrounds
6. The use of the building blocks as the overall organizing scheme allows for these behavioral health care delivery expectations to be overlaid on other work to advance primary care practice

Practice Examples

Practice A

Small independent primary care practice in the rural Midwest

Priority: high rates of substance use disorder (SUD)

Chooses to implement the advanced care of substance use disorders

All patients > 12 screened for SUDs, and those with needs are offered treatment within the practice.

Establishes relationship with local community-based peer support organization for coordinating referrals

Practice B

Midsize primary care practice in the Pacific Northwest

Priority: most patients referred to behavioral health not getting connected

Chooses to implement integrated behavioral health professional and advanced coordination and care management components

All patients screened for depression and anxiety, and those with needs are offered treatment with both medication and counseling within the practice.

Behavioral health professional also available for counseling for other needs that do not fit a diagnosis (eg lifestyle counseling, medication adherence)

Care compact established with local mental health center to develop expectations for mutual patients

Practice C

Large urban primary care practice

Priority: large population of patients with serious mental illness as well as medical co-morbidities that prefer to receive their care in one place.

Chooses to implement the psychiatry component

Psychiatrist comes to the practice twice a month to provide direct patient care, available during the rest of the month for electronic consultations on initiating and adjusting psychiatric medications.

Once a month when the psychiatrist is at the practice, the providers meet together over lunch for a case conference to review particularly challenging cases.

Application to Payment Models

Support for upfront transformation

- Forgivable loans
- Support for practice facilitation

Prospective payment for ongoing costs

- PMPM or calculated lump sum payments
- For entire population
- Risk-adjusted

Behavioral health integration should be the standard of care

Practices want to provide this, patients want to receive this, and payers want to support it.

Questions?

Building Blocks of Behavioral Health Framework eLearning Module

Thank you!

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Policy Insights to Advance Behavioral Health Care in Kansas: Key Findings

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Overview of our key informant interview process

- 24 key informant interviews were conducted, including payers, mental health and substance use disorder professional and advocacy organizations, academic leaders, state agencies
- Semi-structured interview guide that spanned integrated behavioral health challenges, policy solutions, Kansas bright spots, roles for different types of organizations, etc.
- Used a hybrid thematic analysis approach, i.e., both deductive and inductive themes were applied
- Next steps = incorporate feedback from today's session into a final report, alongside analysis insights

Challenges

Challenges cited more frequently

Challenges	Details
Workforce	• Recruitment and retention • Competition re: salary, ideal work locations • Adequate training to meet a wide range of needs • Licensing requirements across state lines
Payment	• Adequate and timely payment for services • Declining and/or differential reimbursement, e.g., lack of uniform coding abilities across different types of professionals • Lack of payment parity across different payers • Concerns about maintaining service lines with rise in uncompensated care
Access	• Limitations and/or capabilities of a center's services • Appointment availability, especially for establish care services • Long waits for specialty referrals and/or beds • Transportation to get to appointments

Challenges cited more frequently

Challenges	Details
Organizational capacity and capability	Questions that warrant discussion among different provider types: - Who does what? - Who is funded to do what? - How can policy allocate appropriate funding for services? - What data informs these decisions? Are these decisions patient-centered? - Where can patients go for which types of services?
Policy and systems design	• Legislative restrictions slow progress, e.g., new law re: changes to Medicaid • Licensure of different types of behavioral health professionals • Inefficiencies are built into the system, e.g., two advisory committees = Kansas Citizens' Committee and Kansas Prescription Drug & Opioid Advisory Committee
Stigma	• Impacts certain populations, e.g., farmers, ranchers • Impacts care settings, e.g., SUD treatment may not be normalized, some behavioral health problems are viewed as too complex to manage

Challenges cited less frequently

Challenges	Details
Administrative harm	• Heterogeneity of billing and coding practices across different settings • Time required to submit and monitor prior authorizations can delay needed care
Data	• Collection can be burdensome for busy practices • State-level data not readily shared or made available for community organizations and providers to use
Politics	• Turnover of politicians affects sustainability • Lack of Medicaid expansion limits service offerings
Collaboration with community partners	• Can be challenged with territorialism over resources, funding, and patients • Trust can be difficult to achieve and maintain with evolving politics and ever-changing regulations

Policy solutions offered by the key informants

Possible policy solutions to address challenges

Challenges	Possible solutions
Workforce	• Build out career pathways in behavioral health like nursing, e.g., CNA, LPN, RN • Limit the number of private practice behavioral health providers • Provide clinics with funding and technical assistance to support integration • Mandate trauma-informed care training in the curriculum for all MH/SUD providers • Train behavioral health professionals in special groups, e.g., rural, school-based • Ease process of becoming licensed by increasing cross-discipline supervision
Payment	• Examine how the state determines reimbursement rates for different levels of behavioral health providers and among different provider types and facilities • Explore payment models to support an expanded care team, such as peers, community health workers, care navigators, and health coaches • Close gaps in enforcing the implementation of existing parity laws • Create clinically integrated networks among rural health clinics/hospitals to increase power to negotiate with commercial payers

Possible policy solutions to address challenges

Challenges	Possible solutions
Access	• Leverage tele-health to address challenges with relative lack of in-house providers • Develop satellite units to increase access to methadone in rural communities • Increase ways for accessing crisis services in an anonymous, confidential manner • Advocate for extension of COVID-19 tele-health capabilities • Build stronger partnerships between SUD and OB providers • Create and fund community-based transportation systems
Policy and systems design	• Examine state regulations that need to be updated and create a plan to do so • Use opioid settlement dollars to experiment with integrating substance use disorder treatment across systems of care in ways that achieve quality outcomes • Examine whether existing legislative and regulatory requirements limit patient choice and access • Address concurrently the broader social drivers impacting health outcomes

Possible policy solutions to address challenges

Challenges	Possible solutions
Stigma	• Provide stigma reduction strategy training to providers and clinic staff • Normalize behavioral health conversations and awareness in different settings, e.g., schools, emergency departments, and primary care clinics • Educate the public, including policymakers, about behavioral health to reduce misinformation
Data	• Publish reports and scorecards evaluating the performance and effectiveness of different care settings in meeting patient needs • Collect, analyze, and report back outcomes data to providers and clinic leaders • Leverage Health Information Exchanges to support collaboration and provide better patient care • Establish a minimum data set that can facilitate exchange of clinical care information across different care settings to ease transitions and promote quality care

Possible policy solutions to address challenges

Challenges	Possible solutions
Collaboration with community partners	• Include patient and family voices in designing solutions • Showcase successful collaboration examples to encourage others to form new partnerships to integrate care • Encourage representation of CCHBCs and FQHCs in each other's professional organizations • Recognize the strengths and roles of mental health and primary care organizations to avoid duplication of services

Keys to success

- **Working better together**
  - Lower competition among organizations serving the underserved
  - Foster trust among professional organizations working in this space
  - Meet patients where they are
  - Reduce stigma at all points in the clinical experience
  - Enhance relationships within communities
  - Fund the time and effort needed to effectively collaborate and ensure accountability to one another
  - Be honest about the history of underfunding and the impact that this has on providing behavioral health services, i.e., are the right things being funded through the right channels
  - Consider facilitation to promote better collaboration and communication
  - Manage protectionism tendencies during resource-scarce times
  - Establish clear working and meeting norms
  - Extend grace to one another
    - “We’re all underfunded … and we’re all well intended.”

Discussion questions

Discussion questions

1) Which of the key findings presented today resonated with or surprised you most?

2) Was anything important missed in the interviews? If so, what?

3) Which policy solutions do you think are most **impactful** and/or most **feasible** to pursue?

4) Which policy solutions do you think are most **feasible** to pursue?


THANK YOU!
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