State Innovation Model (SIM) Grant
Behavioral Health Integration

Background and Overview of Models

January 8, 2016
Overview of Today’s Presentation

- The context of current health care in West Virginia and nationally
- What is Integrated Behavioral Health and Primary Care?
- Why should we integrate BH and PC?
- How does integrated care work in practice?
- What approaches are we recommending for consideration in West Virginia?
- Questions, Discussion, and Reactions
U.S. Healthcare costs too much, wastes too much, and yields poor outcomes

• 30 percent of all Medicare clinical care spending is unnecessary or harmful and could be avoided without worsening health outcomes—Dartmouth

• $690 billion was wasted in US health care annually, not including fraud—Institute of Medicine, 2012

• “Much [of the] waste is driven by the way US health care is organized, delivered, and paid for and, in particular, by the economic incentives in the system that favor volume over value.”—Health Affairs, 2012

• U.S. health care ranks last or near last on dimensions of access, efficiency, and equity—Commonwealth Fund, 2014

• “A major cause of the high cost of health care in America and of many of the serious quality problems in health care is the way healthcare providers are paid.” (Harold Miller, MD)

• “We’ve had no success over the years convincing providers to make changes that weren’t in their financial self interest” (Paraphrase of Bruce Bagley, MD, CEO of TransforMED)

• By 2018, CMS plans to have 50% of all Medicare payment by Alternative Payment Models.

• Movement to Value Based Payment is a key goal of CMS
The Context in West Virginia

- Poor population health—consistently among the worst on both health conditions and BH indicators
  - Highest opiate overdose rate in the nation
  - West Virginia’s suicide rate is higher than any surrounding state — 16.4 deaths per 100,000
- Challenges with hiring & retaining primary care and BH providers -- Even greater challenges with geographic distribution of providers in rural state
- Relatively high spending on health care (12th in the nation; 113% of national average in 2009);
- Modestly below average spending on BH care (rank 30th among States; 78% of national average in 2013)
The Context in West Virginia, cont.

- Recently moved aggressively into managed care for Medicaid—BH only added in July 2015, so there’s little claims history to inform decision making

- Four MCOs, each with differing quality measures, payment approaches, administrative requirements, approaches to behavioral health & care coordination

- Historically and until the present the system has relied almost totally on fee-for-service reimbursement
  - Providers have no experience with alternative payment approaches and difficulty envisioning the future in which payment is tied to value
Examples of many promising practices around the State, but most are limited in scope

- Care coordination, complex care management, super utilizers, CHWs, etc.

Some innovative practices started with grants, then end when the grant expires (e.g., use of Recovery App for people with substance use disorders)

A few FQHCs and CMHCs collaborating to provide whole person care (e.g., SAMHSA PBHCCI grants)

Several FQHCs providing behavioral health services, although the degree of integration not clear
Major Health Issues in West Virginia

West Virginia Health Improvement Areas of Focus

**Obesity**
- Physical Activity
- Nutrition
- Type 2 Diabetes
- Hypertension
- Cardiovascular Disease

**Tobacco**
- Adult Tobacco Utilization
- Youth Tobacco Utilization
- Tobacco Utilization During Pregnancy
- COPD & Associated Cancers
- Smokeless Tobacco & Other Nicotine Products

**Behavioral health**
- Mental Health Provider Availability
- Advancement & Coordination of Mental Health In-Home Services
- Prescription Drug Abuse
- Illegal Substance Abuse
- Neonatal Abstinence Syndrome

Preventable Care & Avoidable Costs

Data/Measurable Outcomes

Community Engagement, Collaboration, Infrastructure
What is Behavioral Health Integration?

Behavioral health integration refers to the care 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 abuse 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.
The Lexicon

Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by Expert Consensus
Important Role of Non-clinical Determinants

http://www.countyhealthrankings.org/resources/county-health-rankings-model
The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
Burden of Mental Illness

• One in 4 Americans struggle with a mental health or substance use problem at some point in their lives. No family goes untouched.

• Mental disorders are responsible for about **25% of all disability worldwide**
  
  - Depression alone accounts for 10% of health related disability.
  - Years Lost to Disability (YLD) from depression are 3x diabetes; 8x heart disease; 40x cancer

  *(Murray C et al; Global Burden of Disease; Lancet, 2012)*

• For governments: high health care costs, high rates of unemployment, homelessness, and involvement in the criminal justice system.

• For employers, mental health & substance use problems are
  
  - Major drivers of absenteeism and presenteeism
  - Major drivers of health care costs, suicide

This and some later slides are adapted from a presentation by Jurgen Unutzer, MD, Professor and Chair, Dept. of Psychiatry and Behavioral Sciences, U. of Washington, & Director of the AIMS Center
BH and High Health Care Costs

“... an estimated $26 - $48 billion can potentially be saved annually through effective integration of medical and behavioral services.” - APA Milliman Report

<table>
<thead>
<tr>
<th>Population</th>
<th>% with behavioral health diagnosis</th>
<th>PMPM without BH diagnosis</th>
<th>PMPM with BH diagnosis</th>
<th>Increase in total PMPM with BH diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>14%</td>
<td>$340</td>
<td>$941</td>
<td>276 %</td>
</tr>
<tr>
<td>Medicare</td>
<td>9%</td>
<td>$583</td>
<td>$1429</td>
<td>245 %</td>
</tr>
<tr>
<td>Medicaid</td>
<td>21%</td>
<td>$381</td>
<td>$1301</td>
<td>341 %</td>
</tr>
<tr>
<td>All insurers</td>
<td>15%</td>
<td>$397</td>
<td>$1085</td>
<td>273 %</td>
</tr>
</tbody>
</table>

Mental health specialty care accounts for only 3% of overall costs.

More effectively integrated mental health care could save billions.

* APA Milliman report; Melek et al; 2013
Care for mental disorders

- 6/10 get NO CARE

- Of those who get care
  - Only 2/10 see a trained mental health professional
  - Most receive treatment in primary care
  - 30 million receive a prescription for a psychiatric medication in primary care
  - Only 1/4 improve

- 2/3 PCPs report poor access to mental health services for their patients

- More than half of counties in US don’t have a single practicing MH professional
## Example: Depression

### Common
- #1 diagnosis in mental health
- Common in primary care (10%)

### Disabling
- 10% of all health-related disability

### Expensive
- 50-100% higher health care costs
- Lost productivity

### Deadly
- Over 30,000 suicides / year

*The Academy: Integrating Behavioral Health and Primary Care*
Mental and Medical Disorders are tightly linked

e.g., Depression & Diabetes

- Smoking
- Sedentary lifestyle
- Obesity
- Lack of adherence to medical regimens
- Psychophysiologic:
  - ↓ Insulin sensitivity
  - ↑ Autonomic nervous system
  - ↑ Inflammatory markers
  - ↑ Cortisol

- Diabetes and CHD at earlier age
- Poor symptom control
- ↑ Functional impairment
- ↑ Complications of medical illness
- ↑ Mortality

Katon et al. Biol Psychiatry 2003
Caring for the Whole Person takes a Team That Works Together

Thanks to the California Integrated Behavioral Health Project: http://www.ibhp.org/
Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care

- Institute of Medicine, 1996
The Four Quadrant Clinical Integration Model

**Quadrant I**

- BH ↓
- PH ↓
- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

**Quadrant II**

- BH ↑
- PH ↓
- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

**Quadrant III**

- BH ↓
- PH ↑
- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

**Quadrant IV**

- BH ↑
- PH ↑
- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.
Task Sharing in Behavioral Health Care

- Hospital
- CMHC
- Outpatient Care
- Collaborative Care Management
- Brief Behavioral Intervention
- Primary Care
- Self Care / Self Management

Specialty Care

Collaborative Care in Primary Care

Primary Care
# Principles of Effective Integrated Behavioral Health Care

## Patient-Centered Team Care / Collaborative Care
- Co-location is not Collaboration. Team members have to learn new skills to work effectively as a team in new roles.

## Population-Based Care
- Patients tracked in a registry: no one ‘falls through the cracks.’ Keeping track of clinical outcomes over time for the population served.

## Measurement-Based Treatment to Target
- Treatments are actively changed until the clinical goals are achieved.

## Evidence-Based Care
- Treatments used are ‘evidence-based’ to the extent possible. Strategies also help to develop practice-based evidence to facilitate continual improvement over time.

## Accountable Care
- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.
Fundamental Principles: Patient- (and Family-) Centered Care

- Relationship-based care that continues over time
- Consideration of patient goals and wishes
- Shared decision making
- Focus on health literacy, patient engagement, patient activation
- Consideration of patient resources and capabilities as part of planning
- Linkage to community resources and consideration of Social Determinants of Health
Fundamental Principles: Measurement and Tracking

• Measurement based care—continual monitoring of patient progress with standard tools

• Population based care—using registries to monitor progress of patient panels and evaluate overall strategy

• Treatment to Target and Stepped Care: Having clear goals and making adjustments to care plan if expected progress isn’t seen over time

• Use of evidence-based care—relying on research and practice-based evidence
Well-coordinated Team-based care, with a care team tailored (as possible) to the needs of the patient

- Team members will need training in how to function as a team
- Likely to include new roles—such as Care Manager, Health Educator, and Community Health Worker/Peer Coach
- Teams may be on site, virtual by telehealth, or a combination of both, as the circumstances dictate
- Using telehealth to make specialized expertise more widely available, educate rural providers
Fundamental Principles: Community Linkage

- Linkage to available community resources, including:
  - Churches and community organizations
  - Schools and school-based health centers
  - Drug and mental health courts
  - Recovery community groups—AA, NA, mental health consumer groups
  - Wellness and fitness programs
  - Outreach to corrections and justice systems
  - Housing with supports as needed
Fundamental Principles: Accountable Care

• Providers are accountable and reimbursed for patient clinical outcomes and quality of care, not just the volume of care provided

• Due consideration to the cost effectiveness of clinical strategies and conservation of resources

• Payment models are designed to align the incentives for Value:
  – Improved patient experience
  – Improved quality of care
  – Conservation of resources

• Minimize (or eliminate) the role of Fee for Service!
Principles of Effective Integrated Behavioral Health Care

Patient-Centered Team Care / Collaborative Care

- Co-location is not Collaboration. Team members have to learn new skills to work effectively as a team in new roles.

Population-Based Care

- Patients tracked in a registry: no one ‘falls through the cracks.’ Keeping track of clinical outcomes over time for the population served.

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are ‘evidence-based’ to the extent possible. Strategies also help to develop practice-based evidence to facilitate continual improvement over time.

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.
WV Challenges to Achieving these Principles

- Extremely limited State resources
  - Hard to make investments in cost-saving innovations
- Relatively weak/early implementation of health information technology—EHRs and HIE
- Limited ability to analyze data to segment population
- Distribution and scarcity of providers
- History of provider-centered care and hard-walled silos
- Resistance to change and organizational rigidity
Questions About the Principles?
How do we close the gap?

• Train & retain more mental health professionals

• Work smarter—Consider the efficiency of our approach!
  ➢ Leverage mental health specialists more effectively
    - partnerships (e.g., primary care)
    - technology (e.g., telemedicine)

• Integration of behavioral health care with primary care has several advantages:
  ➢ Better access to care
  ➢ Better health outcomes
  ➢ Lower costs

= the Triple Aim of health care reform
Examples of Integrated Care

• Collaborative Care (IMPACT, DIAMOND, Washington State Mental Health Improvement Program)
• Comprehensive Primary Care (SHAPE at Colorado’s Rocky Mountain Health Plan)
• Combined FQHC/CMHC (Cherokee Health System)
• FQHC and CMHC Partnerships (PBHCI, Missouri, Washtenaw County)
• Integrated Comprehensive Health Systems (Intermountain Healthcare, Group Health of Puget Sound)
• Many others emerging and growing rapidly
Collaborative Care/Consulting Psychiatrist Model

- Very well suited for mild to moderate BH disabilities (depression, anxiety, excessive drinking) in Primary Care (PC) settings

- Mid-level BH provider (MSW, MA psychologist or counselor), called the Care Manager, joins team in partnership with the PCP

- Use evidence-based brief cognitively oriented psychotherapies (PST, ACT, SBIRT)

- Progress is monitored by regular measurement (PHQ-9, GAD-7, AUDIT, etc.) and recorded in an online registry
Collaborative Care

Primary Care Practice with Mental Health Care Manager

Outcome Measures

Treatment Protocols

Population Registry

Psychiatric Consultation
Collaborative Care/Consulting Psychiatrist Model, cont.

- Care Manager and Psychiatrist regularly review the care registry and identify changes in clinical regimen if patients aren’t improving as expected.
- Consulting psychiatrist works with Care Manager and advises the PCP on medication choices and the Care Manager on therapeutic strategies.
- Psychiatrist time is focused on patients not improving as expected—Treatment to Target, Stepped Care.
- Model proven to be effective & cost effective in 80+ randomized clinical trials over 20 years.
Integrated Care doubles effectiveness of care for depression

50 % or greater improvement in depression at 12 months

Usual Care
IMPACT

Participating Organizations

Unützer et al., JAMA 2002; Psych Clin NA 2004
Integrated Care reduces health care costs  ROI: $ 6.5 saved / $ 1 invested

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td></td>
<td>522</td>
<td>0</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-$3363</td>
</tr>
</tbody>
</table>

Savings

Unützer et al., Am J Managed Care 2008.
Replication studies show: the model is ‘robust’ across clinical problems

<table>
<thead>
<tr>
<th>Clinical Setting</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care for Adolescents</td>
<td>Adolescent Depression</td>
<td>Richardson 2009, 2014</td>
</tr>
<tr>
<td>Adult primary care</td>
<td>Depression &amp; Diabetes Depression, Diabetes, Heart Disease</td>
<td>Katon et al., 2004 Katon et al, 2010</td>
</tr>
<tr>
<td>Latino patients in safety net clinics</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008 Ell et al 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic</td>
<td>Cancer and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Women’s health care clinics (IDAWN)</td>
<td>Depression, PTSD</td>
<td>Melville 2014 Katon 2014</td>
</tr>
<tr>
<td>Adult primary care</td>
<td>Anxiety Disorders including PTSD</td>
<td>Roy-Byrne et al 2012</td>
</tr>
<tr>
<td>Older adults in primary care</td>
<td>Arthritis and depression</td>
<td>Unützer et al., 2008</td>
</tr>
<tr>
<td>Primary Care / Cardiology (COPES)</td>
<td>Heart disease and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>
Over 45,000 case reviews/consultations since 2008: MHIP is a great way to build capacity in our provider community.

“The greatest benefit of the MHIP consultation program may be in the diagnosis and treatment of patients that aren’t even in the program.”
Global Budget - Conventional Network—Rocky Mountain Health Plan, SHAPE Project—BEFORE

- Emergency: 3.7%
- Inpatient: 22.6%
- Outpatient: 18.3%
- Pharmacy: 17.5%
- Specialists: 20.8%
- Primary Care: 4.6%
- Ancillary: 12.5%
Global Budget - Integrated Practices—Rocky Mountain Health Plan, SHAPE Project—AFTER

Emergency 3.4%
Inpatient 20.9%
Outpatient 16.9%
Pharmacy 18.4%
Ancillary 11.5%
Specialists 19.3%
Primary Care 9.1%
Behavioral 0.5%
# Bi-Directional Integration (Missouri)

<table>
<thead>
<tr>
<th>Primary Care Health Homes</th>
<th>CMHC Healthcare Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Behavioral Health Consultants</td>
<td>• Primary Care Consultants</td>
</tr>
<tr>
<td>• SBIRT (web-based)</td>
<td>• Primary Care Nurse Care Managers</td>
</tr>
<tr>
<td>• PHQ 2 screening</td>
<td>• Annual+ Metabolic Screening</td>
</tr>
<tr>
<td>• 6 of 20 Quality Performance Measures are BH</td>
<td>• Diabetes Education</td>
</tr>
<tr>
<td>• 4 of 8 Medication adherence measures are BH</td>
<td>• 10 of 20 Quality Performance Measures are Medical</td>
</tr>
<tr>
<td>• BH prescribing benchmarking and feedback</td>
<td>• 4 of 8 Medication adherence measures are medical</td>
</tr>
</tbody>
</table>

---

**Primary Care Consultants**

**Primary Care Nurse Care Managers**

**Annual+ Metabolic Screening**

**Diabetes Education**

**10 of 20 Quality Performance Measures are Medical**

**4 of 8 Medication adherence measures are medical**
Outcomes: Reducing Hospitalization (Missouri)

% of patients with at least 1 hospitalization
(non-duals, 9+ attestations)

<table>
<thead>
<tr>
<th>Year</th>
<th>CHMC</th>
<th>PC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>35%</td>
<td>30%</td>
</tr>
<tr>
<td>Yr1</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Yr2</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Yr3</td>
<td>20%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Initial Estimated Cost Savings after 18 Months (Missouri)

- **PC Health Homes**
  - 23,354 persons total served (includes Dual Eligibles)
  - Cost Decreased by $30.79 PMPM
  - Total Cost Reduction $7.4 M

- **CMHC Health Homes**
  - 20,031 persons total served (includes Dual Eligibles)
  - Cost Decreased by $76.33 PMPM
  - Total Cost Reduction $15.7 M
FQHC/CMHC Integration Initiative (Missouri)

- Ongoing since 2008
- Seven PC/BH ongoing partnerships ($200K) funded
  - BH services on-site at PC clinic by CMHC
  - PC services on-site at CMHC by PC clinic
- More Organizations are both CMHC and PC
  - Five CMHCs obtained new FQHC status
  - One merger of a CMHC with a FQHC
  - One CMHC acquired a RHC
- More FQHCs have chosen to contract with CMHCs for BH services at other sites beyond the grant rather than develop their own BH services
Project ECHO Model

- Educational model that supports capacity building for challenging healthcare problems
  - University based specialists in complex chronic health problems use a case-based learning model to educate rural/remote providers on evidence based care regimens
  - First WV implementation starting, with Benedum support

- Relatively low cost strategy for improving care quality and making specialist knowledge available in remote areas

- Geographically distributed partner organizations offer ECHO hardware/software and local care teams, as appropriate to the patient characteristics
Consider Project ECHO Model for groups like:

- Hepatitis C (already starting—Cabin Creek & WVU)
- Complex health conditions/high cost/high utilizers (typically including behavioral illnesses)
- Opioid Addiction
- Chronic Pain
- Serious mental illnesses
- Children and youth with serious emotional disturbances
- Early Intervention in Youth with Psychosis
- Geriatric care
Consider partnerships with school-based health centers to integrate BH care for youth with SED or early stage psychotic disorders

In New Mexico, the ECHO model has also been used to train nurses and community health workers

New Mexico has dramatically increased the number of PCPs trained in the use of buprenorphine to treat opioid addiction

ECHO has been adopted by the VA, the DOD, states all over the country, nations all over the world—aiming to improve care to a billion people
Organizational Strategies, Supported by Telehealth

• Expanded use of Medicaid Health Homes, especially for complex, costly patients

• Expanded implementation of Patient Centered Medical Homes—Level 3 that integrate BH and Primary Care

• Expanded partnerships of FQHCs and CMHCs to provide integrated care across the Four Quadrants

• Consideration of Mergers of FQHCs and CMHCs to provide integrated care for all populations

• Increased use of innovative technologies to improve care access and quality, cost effectiveness
WV Based Resources to Support Change

- WV DHHR
- WV Colleges and Universities
- Managed Care Organizations
- Provider Associations
- Demonstration projects currently underway
- Regional Groups of health care and social service providers
- Non-profit groups working to improve healthcare
- Companies that offer services relevant to goals
Additional Resource to Support Implementation: The AHRQ Academy

• The Academy for Integrating Behavioral Health and Primary Care

• A national resource center for the integration of behavioral health and primary care

• Established in 2010 with AHRQ funding

• Taken shape with guidance from a national expert panel, the NIAC

www.integrationacademy.ahrq.gov/
Welcome to the Academy

The AHRQ Academy web portal offers you resources to advance the integration of behavioral health and primary care, and fosters a collaborative environment for dialogue and discussion among relevant thought leaders.

What is Behavioral Health Integration?

[Behavioral Health Integration is] 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 c...

more...

New & Notable

- Fri, 07/15/16 Get your Latest News via the Academy
- Fri, 07/15/16 2014 Healthcare Quality and Disparities Report and Resources
- Fri, 07/15 Cultural Competencies and Diversity Matter in the

Featured Products

Professional Practices: Key Competencies for Integrated Care Delivery
Atlas of Integrated Behavioral Health Care Quality Measures
Lexicon for Behavioral Health and Primary Care Integration
Welcome to the Playbook
A guide to integrating behavioral health in primary care and other ambulatory care settings. To aid in improving health care delivery in order to achieve better patient health outcomes.

John Doe
john-doe@example.org
Edit Account | Log-Out

My Bookmark
Planning for Integration
Define your Vision

Self-Assessment

You haven't taken the Self-Assessment Checklist.

Discover which key functions of integrated behavioral health care are already in place, and which are not. The checklist can help you decide where to focus your attention when you begin your implementation efforts.

Take Assessment

Notes

You don't have any notes saved.

Notes allow you to keep notes while you go through the playbook. Including
Self-Assessment Checklist Results

Started: November 27, 2014  |  Last Update: July 6, 2014

Instructions: Expand the sections below to get Playbook guidance for questions within the section. As you continue to implement integration into your setting, update your responses to assess your progress and identify areas for additional improvement.

Results by Section:

- A Plan for Integrating Behavioral Health and Ambulatory Care
- Operational Systems to Support Integration
- Financial Support for Providing Integrated Behavioral Health and Ambulatory Care
- Data for Patient Identification and Practice Improvement
- Patient and Family Education

STATUS
- In Place
- In Progress
- Not Started
Academy Community
Including Implementation Guide, Curricula
Become a Partner

Our replication partners represent a variety of disciplines across the United States and the world. Every year, more partners find innovative ways to use the ECHO model to increase access and capacity to provide health and educational services.

Become a Replication Partner

- Becoming an ECHO replication partner requires the following:
  1. Learn more about ECHO to see if it fits your local needs and resources. Join one of our training events to learn more and explore the ECHO model.
  2. We ask that partners sign two documents: our Statement of Collaboration for Replicating Partners and our Intellectual Property Terms of Use Agreement. The Terms of Use agreement needs to be customized for each individual partner. Please contact a Replication Program Coordinator at echoreplication@salud.unm.edu.
  3. Join us for immersion training. This can be combined with the Orientation, especially for international partners. We ask that replication partners stay 3 days with us learning the specific best practices of implementing the ECHO model and running a successful teleECHO
SAMHSA-HRSA Center for Integrated Health Solutions

Making Integrated Care Work

CONTACT US: 202.684.7457

SAMHSA-HRSA Center for Integrated Health Solutions

About Us Integrated Care Models Workforce Financing Clinical Practice Operations & Administration Health & Wellness

Glossary

Facebook Twitter Listserv Ask a Question Email

ABOUT CIHS

SAMHSA-HRSA Center for Integrated Health Solutions

CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings.

Blueprint to Success: The Integrated Treatment Plan

Building the roadmap to quality and effective care. Check out the latest eSolutions

LEARN MORE

HOT TOPICS

- eSolutions
- Health IT
- Wellness
- Confidentiality
- Billing Tools
- Workflow
- Partnerships
- HRSA Supported Safety-Net Providers
- Motivational Interviewing
- Tobacco Cessation
- Screening Tools
- HRSA Supported HIV Providers

The Academy

Integrating Behavioral Health and Primary Care
Key Elements of an Integrated System

• To address workforce shortages and maldistribution
  – Broaden support and remove barriers to use of telehealth
  – Project ECHO model using telehealth to make specialist expertise more broadly available throughout West Virginia
  – Collaborative Care/Consulting Psychiatrist model to improve treatment of common, less serious BH disorders in primary care
  – Broaden use of Community Health Workers, Health Educators, Peer Coaches for SUD, and Peer Services for MH—standardize training & certification
  – Revise academic curricula for health professions to support team-based models that integrate BH & primary care
Broader Three Level Telehealth Strategy

• **Level 1:** Conventional Telehealth (Saves travel, improves access)
  - Remove barriers to telehealth parity—allow its use anywhere, anytime; support patient contact site as well

• **Level 2:** Collaborative Care/Consulting Psychiatrist Model (Builds workforce capability over time)
  - Improve the quality & cost effectiveness of BH in primary care settings

• **Level 3:** Project ECHO Model (Educational model)
  - Makes specialized knowledge available to rural/remote providers—reducing isolation & enhancing their effectiveness
Organizational Strategies, Supported by Telehealth

- Expanded use of Medicaid Health Homes, especially for complex, costly patients
- Expanded implementation of Patient Centered Medical Homes—Level 3 that integrate BH and Primary Care
- Expanded partnerships of FQHCs and CMHCs to provide integrated care across the Four Quadrants
- Consideration of Mergers of FQHCs and CMHCs to provide integrated care for all populations
- Increased use of innovative technologies to improve care access and quality, cost effectiveness
Some Thoughts on What to Do First?

- To address the immediate budget crisis:
  - Medicaid Health Homes for Complex, Costly Patients
  - Project ECHO clinic for complex patients, chronic pain, opioid treatment
- Remove barriers to broader telehealth usage
- Move to alternative payment models to make strategies feasible
- Identify resources to support practice change facilitation
- Think about what models and practices fit into your local context and environment
What’s next in West Virginia?

- Use the messages heard today to refine the strategies
- Present ideas and strategies to Steering Committee
- Examine Behavioral Health Integration Strategies in the context of the overall plan, including the shift to alternative payment methods
- Identify organizational and personnel resources to support necessary changes
- Develop detailed implementation plan with milestones, timelines, and budgets
- Get to work!
Thanks for your attention!

Thanks to Jurgen Unutzer, Joe Parks, and Kathy Reynolds for the use of their slides.

Questions welcome!

Garrett E. Moran, Ph.D.
GarrettMoran@Westat.com
(301) 294-3821
1600 Research Blvd.
Rockville, MD 20850