Integration Innovations: A Discussion with Federal Agencies (Webinar Part I of II)
How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group.  (left)

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions.  (right)
The AHRQ Academy for Integrating Behavioral Health and Primary Care

July 31, 2013
AHRQ’s Focus on Integrating Behavioral Health and Primary Care (BH/PC)

- AHRQ published a comprehensive review ("Integration of Mental Health/Substance Abuse and Primary Care") of the available evidence on integrated BH/PC in 2008
- AHRQ funded a research agenda conference grant in 2009 which resulted in an early Lexicon draft
- A paper on the Future Research Needs for Integration followed in 2010
- The AHRQ report, National Research Agenda for Collaborative Care was released in 2011
- The Academy was initially funded in 2010, and quality measures, survey, and workforce tasks added in 2011
AHRQ’s vision is for the Academy for Integrating Behavioral Health and Primary Care to:

- Function as a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare
- Focus particularly on integrating behavioral health care into primary care practices
- Promote a collaborative environment that fosters dialogue among leaders and other stakeholders in integrating BH/PC
- Collect, synthesize, and disseminate useful information to policymakers, researchers, providers, and consumers
- Provide tools and materials to advance integrated healthcare
Key Academy Tasks

- **National Integration Academy Council (NIAC)**
  Nationally recognized leaders in integrated healthcare serve as a sounding board and expert panel, helping identify opportunities to impact the field

- **Web Portal**
  Provides literature, collects resources, disseminates new products, and provides a place for stakeholders to interact

- **Literature Repository**
  With more than 1,900 citations, updated continually, key and foundational literature – both peer-reviewed and grey
Key Academy Tasks, cont.

- Developed a *Lexicon for Behavioral Health and Primary Care Integration*

  Working to develop conceptual and definitional clarity around integrated BH/PC. NIAC member Dr. C. J. Peek led this effort with targeted funding from AHRQ.

- **Workforce Competencies**

  Direct practice observation of selected exemplary primary care practices to identify how staff members collaborate effectively across disciplines and specialties to serve the whole patient.
Key Academy Tasks, cont.

- **Survey of Smaller and Independent Primary Care Practices**
  Developing and piloting instrumentation, methods, and information about how primary care practices are currently addressing behavioral health issues

- **Atlas of Integrated Behavioral Health Quality Measures**
  Builds on the conceptual framework of the Lexicon to identify available measures of integrated BH/PC and key components thereof
Lexicon for Behavioral Health and Primary Care Integration

What’s in a name?
“All mature scientific fields have lexicons (systems of terms and concepts) that allow geographically distributed work to take place. ... for practical communication and collaboration among those doing the work of science and practice”. The new Lexicon for Behavioral Health and Primary Care Integration is now available.

The Academy Web Portal – A Resource Hub

Welcome to this new AHRQ Web portal where you will find the resources you need to advance the integration of primary care and behavioral health care and foster a collaborative environment for dialogue and discussion among relevant thought leaders.

This resource center will facilitate the work of the Academy by being a central hub for information, coordination, dissemination, and networking. The portal is structured around seven topics: Research, Education, Policy, Financing & Sustainability, Clinical & Community, Health Information Technology, Resources, and Collaboration.

Information related to integration will include evidence-based practices, descriptions of promising practices, and articles on methods used to acquire evidence. The portal will be enhanced by adding coordination, dissemination, and networking functions including Webinars and forums.
Macaran (Mac) Baird, MD, MS

Macaran (Mac) Baird, MD, MS is professor and head of the University of Minnesota Department of Family Medicine and Community Health. His research focuses on the integration of behavioral medicine into primary care medicine, population-based health, family therapy, and chronic illness. For the past three years, Dr. Baird has...

Read More about Macaran (Mac) Baird, MD, MS
View PubMed citations for Macaran Baird

Alexander Blount, EdD

Alexander Blount, EdD, is Professor of Family Medicine and Psychiatry at the University of Massachusetts Medical School in Worcester, MA, and Director of Behavioral Science in the Department of Family Medicine and Community Health. He teaches physicians the psychosocial skills of primary care practice and established the post-...
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8 Do's & Don'ts of Mental Health: Integrating Behavioral Health Treatment into Primary Care Practice, McLeod, A.; and Cordes, C. C., Advance for NPs & PAs. Volume 2, Issue 6, p.35 - 36 (2011)

Export Citation: BibTex Tagged RIS RTF XML

View Pubmed Citation
Goal of the Lexicon was to develop conceptual & definitional clarity.

Provides a basis for effective research and communication for all stakeholders.

The Lexicon serves as the foundation for much of the Academy’s work.
What is Integrated Behavioral/Primary Care?

The care a patient experiences as a result of a 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.
Requirements for “Lexicon” Development Method:

A. Consensual but analytic
   (a disciplined process -- not a political campaign)

B. Involving “native speakers” (in this case 24 diverse)
   (implementers and users)

C. Focused on what functionalities look like in practice
   (not just principles, values, abstractions)

D. Amenable to gathering an expanding circle of “owners”
   and contributors
   (not just an elite group coming with a declaration)

Method: Paradigm Case Formulation and Parametric Analysis

Ossorio (2006); The Behavior of Persons. Descriptive Psychology Press, Ann Arbor
Patients & families:
• What do I want and expect as a standard of practice?
• How would I recognize it if I saw it?
• How would I know if what I see is up to standard?

Clinician & system implementers:
• What exactly do I implement?
• What are the core functions and what do I locally adapt?

Purchasers/plans:
• What exactly am I buying?
• What do I tell employees or members what to expect for the cost?

Policymakers & business modelers:
• If asked to change rules of the game or business models, what functions need to be supported?
• Says who?

Researchers:
• What comparisons of effectiveness?
• What terms for asking consistently understood questions across PBRN’s?
Workforce Competencies: The need

- Broad recognition of need to identify training competencies for primary care and behavioral health
- To date, most efforts have been discipline specific, consensus driven, and based on the literature
- Few efforts have fully addressed the practice variation that occurs when integrated care research is translated into practice
Workforce Competencies: Our approach

- Integrated practices are selected based on a set of “exemplary” criteria, such as:
  - Are BH professionals actively communicating and collaborating with other providers in the clinic, in the delivery of patient care?
  - Is there a shared treatment plan developed and followed by all members of the care team?
  - Is the patient record keeping system used by all members of the care team?

- *Direct Practice Observation*—a trained team of four qualitative researchers spends four days observing the care teams, talking to specific stakeholders, and understanding the practice culture and workflow—will visit a total of 10 practices
Workforce Competencies: The products

- A literature review that will allow comparison of the published literature and the findings from the practice observation
- Identification of a sample of 10 exemplar practices of diverse types (FQHC, integrated systems, etc.)
- Provider and practice level competencies will be identified in the final report, tied to the dimensions identified in the Lexicon
- A final accessible guidebook of competencies will be released through AHRQ and the Academy
Survey of Physicians in Solo and Smaller Practices

- Purpose: To understand how physicians in solo and smaller group practices currently manage and treat patients with behavioral health issues

- Smaller practices identified as those with 10 or fewer physicians

- These practices targeted because relatively little is known about how they deal with behavioral concerns, yet they serve a sizable proportion of the population
  
  - 80% of patients with BH disorders are seen primarily in the general medical sector, including 60% of patients with severe depression*

*Kathol (2013). Economic Arguments for the Integration of Behavioral Health into Primary Care.
Survey Main Topics

- Does the primary care physician (PCP) evaluate behavioral health using standardized screening instruments?
- Does the PCP use any standardized models for treating behavioral health?
- Does the PCP have established working relationships with any behavioral health providers?
- How do the PCP and behavioral health provider(s) work together to develop a treatment plan?
- How is the PCP reimbursed for the behavioral health services?
Survey Methods

- Exploratory and cognitive interviews to design the questionnaire
- Survey with 300 PCPs
- Follow-up in-depth interviews with 30 PCPs who responded to the survey
- PCPs selected from the National Plan and Provider Enumeration System (NPPES)
- Mail Survey
- Data Collection Completed on June 1, 2013 and Analysis is in Progress
Purpose
To support the field of integrated behavioral health care measurement by:
• Presenting a framework for understanding measurement of integrated behavioral health care;
• Providing a list of existing measures relevant to measuring integrated behavioral health care; and
• Presenting the framework and measures in a user friendly format

Intended Audience
• Practices/Health Systems implementing models of integrated care
• Researchers & measurement experts
Atlas of Integrated Behavioral Health Care Quality Measures

Purpose

Integrated behavioral health care is an emerging field with the potential to improve health outcomes for patients and health care delivery within practices. Integrated behavioral health care can systematically enhance a primary care practice’s ability to effectively address behavioral health issues that naturally emerge in the primary care, prevent fragmentation between behavioral health and medical care, and create effective relationships with mental health specialists outside the primary care setting.

As greater numbers of primary care practices and health systems begin to design and implement integrated behavioral health services, there is a growing need for quality measures that are rigorous and appropriate to the specific characteristics
The Academy: What’s Next?

• Findings from the Survey will be finalized and published by September, providing key information on how solo and smaller primary care practices currently address patients’ BH issues

• IBHC Measures Atlas went live on the Academy Portal – July 26, 2013
  – Environmental scan continues to update the Atlas with additional measures

• Workforce Competencies from Practice Observation should be published on the AHRQ Academy portal in mid-2014

• Continuing to enhance the Academy web portal with new content and functions (Mapping, community interaction, more webinars on financing, policy, and practice related to integrated BH/PC, etc.)
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- Benjamin Miller, PsyD, Principal Investigator - UC Denver Benjamin.Miller@ucdenver.edu
- Vasudha Narayanan, Senior Study Director - Westat VasudhaNarayanan@Westat.com
Dedicated to promoting 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 specialty behavioral health or primary care provider settings.
About the Center

In partnership with Health & Human Services (HHS)/Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA).

Purpose:

- To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development.

- To provide technical assistance to SAMHSA PBHCI grantees and HRSA funded safety-net providers to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders.

- To develop and disseminate practical tools and resources in the hands of community-based behavioral health and primary care providers working to increase the quality of health and behavioral health services.
Center for Integrated Health Solutions

Target Populations
- SAMHSA Primary & Behavioral Health Care Integration (PBHCI) Grantees
- HRSA funded Safety-net Providers
- Behavioral Health / Primary Care Practitioners

Services
- Training and Technical Assistance
- Knowledge Development and Dissemination
- Prevention and Health Promotion/ Wellness
- Workforce Development
SAMHSA PBHCI Grants

Community Behavioral Health Organizations

- 78% partnering with an FQHC
- Majority are CMHCs, ~10% are SA providers
- Served over 32,000 adults with SMI and/or COD

Grantee Cohorts:

- 13 awarded 2009
- 43 awarded 2010
- 8 awarded 2011
- 29 awarded 2012
- 7 awarded 2013
SAMHSA-HRSA Center for Integrated Health Solutions

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 specialty behavioral health or primary care provider settings.

LEARN MORE

Prescribing for Addictions

Addiction Expert Calls for More Physician Training in Prescribing Buprenorphine

Click here for details

In the News

Wall Street Journal highlights AHRQ campaign

NY Times: Exec Job as Defense Against Mental Illness

New York Times continues its mental illness series
Integration Models

*Reviewing integration models* and strategies and helping select the one best suited to a state or provider's needs;

Training providers on bidirectional integration and *lessons learned from integration sites* from across the country;

*Supporting state planning teams* (including Medicaid directors, insurance commissioners, and directors of state behavioral health and primary care agencies) with technical assistance to develop statewide systems change;

*Engaging consumers and family members* in the state planning process and in determining appropriate models and/or strategies; and
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<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
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<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 4 Close Collaboration Onsite with Some System Integration</td>
<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
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<tr>
<td>Behavioral health, primary care and other healthcare providers work:</td>
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<tr>
<td>In separate facilities, where they:</td>
<td>In same space within the same facility, where they:</td>
<td>In same space within the same facility, sharing all practice space, where they:</td>
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<tr>
<td>Have separate systems</td>
<td>Share some systems, like scheduling or medical records</td>
<td>&gt;&gt; Have resolved most or all system issues, functioning as one integrated system</td>
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<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate in person as needed</td>
<td>Communicate consistently at the system, team and individual levels</td>
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<td>Communicate, driven by provider need</td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
<td>Collaborate, driven by desire to be a member of the care team</td>
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<td>May never meet in person</td>
<td>Have regular face-to-face interactions about some patients</td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
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<td>Have limited understanding of each other’s roles</td>
<td>Have a basic understanding of roles and culture</td>
<td>Have an in-depth understanding of roles and culture</td>
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<td>&gt;&gt; Have separate systems</td>
<td>&gt;&gt; Have separate systems</td>
<td>&gt;&gt; Have formal and informal meetings to support integrated model of care</td>
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<td>&gt;&gt; Communicate periodically about shared patients</td>
<td>&gt;&gt; Communicate regularly about shared patients, by phone or e-mail</td>
<td>&gt;&gt; Have roles and cultures that blur or blend</td>
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<td>&gt;&gt; Communicate, driven by specific patient issues</td>
<td>&gt;&gt; Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>&gt;&gt; Collaborate, driven by shared concept of team care</td>
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<td>&gt;&gt; May meet as part of larger community</td>
<td>&gt;&gt; Meet occasionally to discuss cases due to close proximity</td>
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<tr>
<td>&gt;&gt; Appreciate each other’s roles as resources</td>
<td>&gt;&gt; Feel part of a larger yet ill-defined team</td>
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Moving Toward Behavioral Health Homes for People with Mental Health & Substance Use Conditions
CIHS and Financing

Analyzing integrated health staffing and billing structures;

Working with SAMHSA PBHCI grantees to sustain grant funded wellness interventions

Supporting state dialogues on efforts to address same day billing, identified billing codes;

Sharing lessons learned from integration sites from across the country;

Fostering private foundation support for state and local integration efforts.
Who Can Bill, for What, and By Whom – CIHS Interim Billing Worksheets

- Point in time review of each state’s Medicaid program on what may or may not be reimbursable in your state for integration using currently available codes
- Point in time review of Medicare reimbursement
- Link CPT, Diagnostic Code and Credential
- One of many tools – a place to start the conversation and billing locally and in a state
- Do not GUARANTEE you will be paid based on the worksheet

Worksheets Available at:

www.integration.samhsa.gov
CIHS and Clinical Practice Information

- **Engaging** substance use/mental health/FQHC leaders to identify and discuss key areas for collaboration
- **Implementing Medication Assisted Treatment** FQHC/specialty behavioral health collaborations
- **Curating web-based resources and screening tools** on the CIHS website
- **Providing technical assistance for SBIRT** implementation in FQHCs
- Exploring the **role of case managers** in support health goals as part of an individual’s recovery goals
Examples of Capacity Building

- CHC Behavioral Health Integration Learning Community
  - Business Case for Behavioral Health Integration Monograph
- Timely Access to Specialty Mental Health and Substance Use Treatment through Expansion of Tele-Behavioral Health Services in Rural Area Learning Community
- SBIRT Training and Technical Assistance for Safety-net Provider
CIHS and the Integrated Health Workforce

Producing and implementing integrated health education curriculum and resources for:

- Psychiatrists Working in Primary Care
- Consumers serving as Peer Educators
- Case Managers as Health Navigators
- Addiction Professionals Working in Primary Care
- Primary Care Physicians Working in Behavioral Health Settings
- Care Management in Primary Care for current Behavioral Health Workforce
- Mental Health First Aiders in Rural Communities
- Social Worker Standard of Practice and Field Placement
CIHS and Clinical Operations

*Offering training webinars & resources* on contracting, confidentiality; sustainability;

*Curating examples* of MOUs, clinical workflows, integrated treatment plans, policy and procedures;

*Developing 42 CFR Part 2 Consent Management Resource* for states and providers; and

*Promoting innovative strategies* and tools used by the SAMHSA PBHCI grantees.
Sustainability Checklist

Administrative Sustainability
- Organizational Infrastructure
- Human Resources
- Health Information Technology

Clinical Sustainability
- Consumers
- Medical Staff
- Behavioral Health Staff

Financial Sustainability
- Billing and Reimbursement
## Examples of CIHS National Webinars

| Motivational Interviewing for Better Health Outcomes | Peer Support Wellness Respite Centers |
| Implementing SBIRT in Clinical Settings | Person-Centered Health Homes |
| Billing for Integrated Health Services | Establishing Smoking Cessation Initiatives in Health Centers |
| Brief Behavioral Health Interventions in Primary Care | Coordinating Services Among People Who are Homeless |
| Chronic Pain: An Integrated Care Approach | Addressing Obesity and Chronic Illness Among People with Mental Illnesses |
| Engagement for Whole Health and Wellness | Clinical Workflows |
| Tobacco Cessation in Behavioral Health Settings | Team Approaches to Care Coordination |
CIHS and Health Promotion/Wellness

Identifying *evidence-based programs* designed to support health promotion with individuals with SMI

**Whole Health Action Management (WHAM)** – expanding the role of peers to support the development of action plans and tracking

Organizational *decision supports* to help organizations choose peer-based programs

Targeted technical assistance on implementing clinical and organizational strategies for *tobacco cessation*
Health Promotion Programs for Persons with Serious MI

- Reducing obesity and improving fitness in adults with SMI is challenging but possible, and requires a multi-component, intensive, evidence-based approach.

- The best studies demonstrate modest results in reducing obesity but better results in improving fitness.

- **What works better?** Intensive manualized programs that combine coached physical activity and dietary change lasting at least 6 months (or more).

- Clinically significant weight loss is likely to be achieved by some, but improved fitness by more..... both are important for heart health.
Coming Soon from CIHS….

- Organizational Assessment Tools for Integration
- Updated State Billing Worksheets
- Decision Support Matrix of Peer Wellness Programs
- Workforce Resources (Sample Job Descriptions)
- White Paper on Primary and Behavioral Healthcare Integration for Children and Adolescents
- White Paper on Medicaid Health Homes Financing
- PBHCI Field Guide
Contact Information

Keep In Touch
Subscribe to eSolutions, CIHS’ monthly newsletter
Join the PC-BH Integration listserv

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.