

August 26th, 2014

Behavioral Health Integration Capacity Assessment (BHICA) Introductory Webinar



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Webinar Agenda

- Purpose of today's webinar
- Introduce the Behavioral Health Integration Capacity Assessment (BHICA)
- Demonstrate how to use and evaluate the BHICA
- Invite feedback and questions on the content, structure, and dissemination of the BHICA

Purpose

Launch a resource for behavioral health organizations seeking to integrate primary care services.

Participants



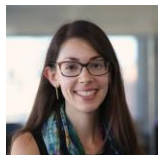
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The Behavioral Health Integration Capacity Assessment (BHICA)

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BHICA: Objectives

- To assist behavioral health organizations in evaluating their ability to implement integrated care.
- After completing the assessment organizations will be able to:
 - Consider potential approaches to integration to better serve the clientele of their organization;
 - Understand the current infrastructure of the organization to support greater integration;
 - Assess the organization's strengths and challenges in undertaking different approaches to integration; and
 - Set and prioritize goals for the organization's integration efforts.

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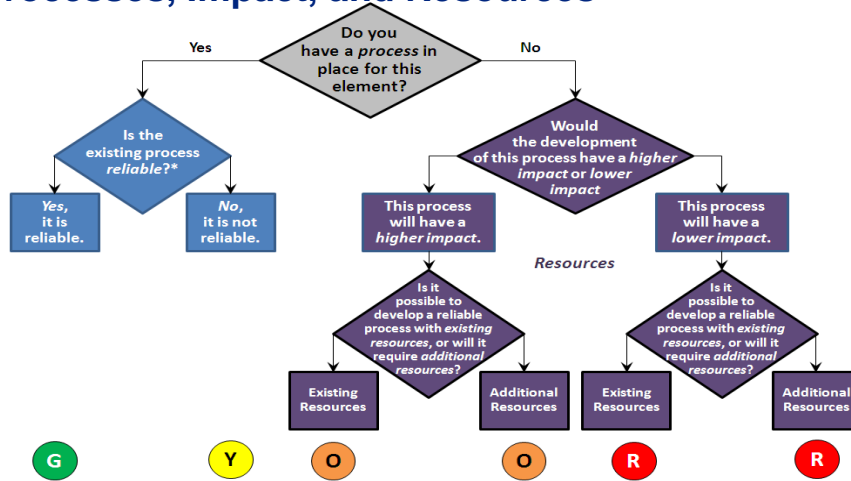
BHICA: Structure

- Introduction to integrated care
- Five sections of tool:
 - Part One: Understanding Your Population
 - Part Two: Assessing Your Infrastructure
 - Part Three: Identifying the Population and Matching Care
 - Part Four: Assessing the Optimal Integration Approach for Your Organization
 - Part Five: Financing Integration
- Information on how to evaluate and interpret self-assessment results

Using the BHICA

- BHICA is intended for use by behavioral health organizations and behavioral health providers.
- Typically completed by staff members with expertise at all levels of the organization.
 - Ex: finance, operations, clinical processes, leadership, front-line staff.
- Completed as a group or individually with opportunity to discuss results and next steps together.
- Could take between 90 minutes or a full day or more for more in-depth analysis and conversations.

Evaluation Framework Linked to Organization Processes, Impact, and Resources



*Reliability is defined as a "failure-free operation over time." In health care, it is feasible to achieve 95% reliability for the majority of care-related processes. One simple way to assess reliability is to predict if five front-line individuals are able to accurately describe the process in the same way. If you are not confident that all five individuals are able to do so, evaluate this process as not reliable.

Part 1: Understand Your Population

- Help organizations consider how individuals' characteristics and needs affect potential approaches to integration.
- Organizations may not be able to answer all questions.
- Organizations that have already analyzed their data or selected an approach do not need to complete this section.
- Data may be collected through a variety of sources
 - Electronic health records
 - Claims data
 - Conversations with individuals and providers
 - Other sources
- Part 1 is for self-reflection and will not be scored

Part 1: Key Questions

- Total number of individuals seen in the past 12 months
- Total number of visits in the past 12 months
- Most prevalent (top five) mental health and substance abuse diagnoses for all individuals
- Most prevalent physical health diagnoses for all individuals
- Percentage of your population with multiple chronic conditions
- Percentage of your population that does not have a PCP

Part 1 Sample

1. Understanding Your Population

The following questions will help you consider how client needs may affect potential approaches to integration. You may not be able to answer all questions asked below because they may depend on your ability to measure the needs of your population (collect and interpret data on demographics and the population's mental and physical health conditions, as well as their desire for specific service types and methods). This information, however, will help in thinking about the appropriate integration approach. For example, if 75% of the population already has primary care providers, building integration in-house may not be necessary, as the primary care needs of many individuals are already being met. In that case, building formal or informal relationships with local primary care providers may be the best option. Conversely, a population with significant physical health needs and low primary care coverage may benefit from a more intensive integration approach to best meet their needs. Your organization may find these data through a variety of sources, such as individuals' electronic health records, claims data, conversation with individuals and providers, and other sources. For some organizations, these questions will identify opportunities to collect additional information on the population. This section will not be "scored"; rather, leaders and staff may use their responses to reflect on the needs of the population and the current organizational capacity to measure those needs. Each of the three sections in "Assessing the Optimal Integration Approach for Your Practice" includes notes about how to use this information to identify a path forward.

• Describe the population you serve:

Most prevalent (top five) mental health diagnoses:

Most prevalent (top five) substance abuse diagnoses (including tobacco and alcohol):

Part 2: Assessing Your Infrastructure

- Evaluate your organization's current operational and cultural practices to identify specific recommendations for improvement.
- Five core operational capabilities:
 - 1) Capacity to Collect Data, Exchange Information, and Monitor Population Health
 - 2) Progress and Outcome Tracking Capability
 - 3) Process for Engaging and Communicating with Individuals and Family Members
 - 4) Community Wellness Resources
 - 5) Culture to Support Integration: Leadership Culture and Provider and Staff Engagement

2.1: Capacity to Collect Data, Exchange Information, and Monitor Population Health

- Core Capability: *Organizations use an electronic health record or other methods to collect individual and practice-level data that allows them to identify, track, and segment the population.*
- Key Questions:
 - Does your organization routinely collect individual-level data? For example, data on visits, diagnoses, and clinical outcomes
 - Do you record the names of individuals' primary care providers? The date of individuals' last primary care visit?
 - Does your organization use an electronic health record (EHR)?
 - Is your EHR able to interface with other systems outside of the organization?

2.2: Progress and Outcome Tracking Capability

- Core Capability: *The organization is able to measure the effectiveness of the treatment provided.*
- Key Questions:
 - Does your organization track medication use?
 - Does your organization track lab work?
 - Does your organization track individual changes in health outcomes, behavioral health outcomes, and health behaviors?
 - Does your organization use the individual-level data it collects to determine what kinds of improvements or adjustments to make in clinical care or organizational processes?
 - Does your organization track provider satisfaction measures?

2.3: Process for Engaging and Communicating with Individuals and Family Members

- Core Capability: *Behavioral health and primary care providers have supportive, consistent, and clear communication with individuals and their families or natural supports.*
- Key Questions:
 - Do providers engage with individuals and/or families about setting treatment goals?
 - Do providers communicate with individuals and/or families about diagnoses, level of disability, and level of functioning?
 - Do providers include the individual and/or family in developing the treatment and recovery support plan?
 - Are HIPAA provisions and consents for sharing protected information in place?

2.4: Community Wellness Resources

- Core Capability: *The organization provides individuals with resources that promote wellness.*
- Key Questions:
 - Does the organization provide individuals with materials to encourage them to ask providers about physical health problems?
 - Does the organization support clients in self-management of chronic illnesses?
 - Does the organization maintain a list of local wellness activities that would be appropriate for individuals with mental illness?
 - Does the organization offer wellness programs?

2.5: Leadership Culture

- Core Capability: *There is administrative support and leadership buy-in to pursue integration, encourage change, and remove barriers.*
- Key Questions (yes/no):
 - Leaders actively support the concepts of integration.
 - Moving towards integrated care is a key component of the organization's strategic plan.
 - The organization's policies allow for flexibility in job roles.
 - Leaders encourage active discussions about incorporating changes into the practice.
 - Financial leaders are involved in creating the business plan for increased integration.

2.5: Provider and Staff Engagement

- **Core Capability:** *Staff is committed to making changes to accommodate integration efforts. Behavioral health and primary care providers are comfortable working with each other.*
- **Key Questions (yes/no):**
 - Staff members have a basic understanding of the principles of integration.
 - Staff members would feel comfortable working with a member of the primary care team in designing a joint treatment and recovery support plan.
 - Staff members are willing to make changes to their work habits to accommodate offering integrated services.
 - Staff members embrace a whole person approach to care.

Sample of Part 2

2. Assessing Your Infrastructure

Providers and organizations that want to move towards integration need to address five core operational capabilities: 1) Capacity to Collect Data, Exchange Information, and Monitor Population Health; 2) Progress and Outcome Tracking Capability; 3) Process for Engaging and Communicating with Individuals and Family Members; 4) Community Wellness Resources; and 5) Culture to Support Integration.

2.1. Capacity to Collect Data, Exchange Information, and Monitor Population Health

Capability: Organizations use an electronic health record (EHR) to collect individual and practice-level data that allows them to track, identify and segment the population. Ideally, organizations have a reliable system for collecting data that supports aggregation of data, information sharing, and identification of high-risk populations.

2.1.1 Does your organization routinely collect individual-level data?

For example, data on individuals' visits, diagnoses, and clinical outcomes

Do you have a process in place?
<input type="radio"/> Yes
<input type="radio"/> No
Is this process reliable?
<input type="radio"/> Yes
<input type="radio"/> No
Would the development of this process have a higher impact?
<input type="radio"/> Yes
<input type="radio"/> No
Is it possible to develop a reliable process with existing resources?
<input type="radio"/> Yes
<input type="radio"/> No
Result
<input type="text"/>

Part 3: Identifying the Population and Matching Care

Organizations must have a process in place to identify the population they want to serve or reach and a way to match individuals' needs to the appropriate care.

Part 3: Core Capabilities

- 1) The organization provides comprehensive, universal screening of the population that allows for identification of the individuals to receive focused tracking and intervention.
- 2) The appropriate staff member is designated to reliably carry out each function related to screening. Alternatively, your organization may also choose to designate a group of staff members to take on this task in addition to their clinical responsibilities.
- 3) Organizations use screening results and other data to segment the client population into groups requiring different levels or types of care.

Part 4: Assessing the Optimal Integration Approach

- The selected approach will depend on the organization's aim, resources, capacity, and financial arrangements.
- Processes to achieve integration will differ by organization.
 - Organizations can take a hybrid approach that draws on key processes from each section.
- Three approaches
 - 1) Coordinate Care
 - 2) Co-locate Primary Care Services
 - 3) Build primary care capability in house
- Organizations can answer any or all of the sections depending on goals and interests.

Part 4: Coordinate Care

- Referrals to and Communication with Community Organizations and Support Agencies
- Referrals to and Relationships with Physical Health Resources and Primary and Tertiary Care Providers
- Build Relationships and Exchange Information with Primary Care Providers
- Assist Individuals with no Primary Care Providers

Part 4: Co-Locate Primary Care Services

- Access to Primary Care Services
- Provide Navigation and/or Care Coordination Services

Part 4: Build Primary Care Capability In-House

- Provide Navigation and/or Care Coordination Services
- Screening Functions
- Provide Primary Care Services
- Space, Supplies, and Materials
- Access to Primary Care Services
- Enhanced Communication among Providers

Part 5: Financing Integration

- Integration as a clinical model requires an integrated financial model in order to succeed.
- Organizations must often create unique strategies to offset the cost of the new integrated services.
- Each integration approach has unique financial issues.
- Organizations should consider existing primary care and behavioral health reimbursement mechanisms.
- Creative, collaborative solutions will be necessary.

Part 5: Key Questions

- Has the practice identified billing procedures and related processes for each integration-related billing activity?
- Does the practice currently participate in integration-related activities that are not billable?
- Does your organization have a relationship with a hospital or health system that is participating in an Accountable Care Organization (ACO)?
- Is your organization aware of demonstrations and/or initiatives in your state or region that would be applicable to your efforts?
- Is your organization aware of federal rules, regulations, and incentives to integrate care?
- Does your organization collect information on current use of acute care services (e.g., readmissions or ER visits) to build a business case that increased primary care use can decrease overall health care costs?

Poll Question

Moving towards integrated care is a key component of the organization's strategic plan.

- a) Yes
- b) No
- c) In process

Poll Question

As you reflect on your planning for health integration, do you wish you had conducted a baseline assessment and tracked your progress on:

- a. Understanding your population
- b. Assessing your infrastructure (e.g. your capacity to collect data)
- c. Identifying the population and matching care
- d. Assessing the optimal integration approach

Using the Completed Survey results of the BHICA

- **Types of planning activities that the results might enable:**
 - Establish “aspirational goals” for your organization for each area scored/some of the areas scored...“Where can we go from here?”
 - Use the results as part of your organizations TQI process; reshape the work plan and work flows accordingly
 - Examine your resource capacity to get where you need to go next:
 - Do we have the resources we need to transform the area of practice we are targeting for change?
 - If not, can we get the resources?
 - Where can we go to get those resources?

Using the Completed Survey results of the BHICA







- **Use the results to build “champions” for integration and develop leadership to help implement the approach**
 - Identify your strengths and weaknesses and where partnerships will be required
 - If we don’t have a partner and need one, where can we go to secure that partner?
 - Build a multi-disciplinary team – include consumers, students, volunteers
- **Build a project cost model that includes the administrative overhead that will be needed to implement your approach**
 - Results can help you focus in on and plan for what it will take administratively to implement integration, beyond the clinical needs
- **“Mature” your integration approach based on the results**
 - Pick one area that you want to strengthen and focus on improvement/growth
 - Use it to build team cohesiveness around characteristics of good patient care

Demonstration and Scoring the BHICA

Electronic Evaluation Form

Table 1 Self-Assessment: Your Infrastructure					
	Process	Reliable	Impact	Resources	Notes
2. Assessing Your Infrastructure					
2.1. Capacity to Collect Data, Exchange Information, and Monitor Population Health					
2.1.1 Does your organization routinely collect individual-level data?					
2.1.2 Does your organization routinely aggregate individual-level data?					
2.1.3 Do you record the names of individuals' primary care providers?					
2.1.4 Do you record the date of individuals' last primary care visit?					
2.1.5 Do you record progress notes/the nature of the last primary care visit?					
2.1.6 Do you record the names of individuals' home and community-based supports?					
2.1.7 Do you record the number of past-year hospitalizations for both psychiatric and medical reasons?					
2.1.8 Do you record the number of individuals' past-year ER visits for both psychiatric and medical reasons?					

Interpreting Self-Assessment Results

ASSESSMENT CATEGORY	PROCESS	RELIABILITY	IMPACT	RESOURCES	Interpretation
	Y	Yes	—	—	Reliable process for the element. No further action required.
	Y	No	—	—	There is a process for this element, but it is not yet reliable.
	N	—	Higher	Yes	Could create a reliable process with existing resources and will have a higher impact on the population you serve.
	N	—	Higher	No	Require additional resources to create a reliable process and will have a higher impact on the population you serve.
	N	—	Lower	Yes	Could create a reliable process with existing resources but will have a lower impact on the population you serve.
	N	—	Lower	No	Require additional resources to create a reliable process and would have a lower impact on the population you serve.

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Testers and Reviewers

- Greater Nashua Mental Health Center (NH)
- Tri-County Mental Health Services (ME)
- Cambridge Health Alliance (MA)
- Axis Health System (CO)
- Community Health and Counseling Services (ME)
- Providence Center (RI)
- Massachusetts General Hospital (MA)

- In addition, feedback was provided by representatives from state government (e.g., Kansas), federal agencies (e.g., SAHMSA), and key organizations (e.g., Center for Health Care Strategies).

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Feedback from Testing the BHICA

- Organizations testing the BHICA believe it will be useful to providers and found it helpful to understand areas where their care was optimal as well as areas for improvement.
- The tool is very comprehensive but also somewhat long. Organizations may select approaches so they do not have to complete the entire assessment.
- Adapted for use with substance abuse providers based on feedback from the field.

BHICA Dissemination, Additional Resources, and Next Steps

BHICA Dissemination and Related Resources

- As of August 2014, there were 7,604 page views on the Resources for Integrated Care and IHI websites.
- Our goal is to make the BHICA widely available to all interested behavioral health organizations and other stakeholders.
 - Free and voluntary
 - Paper and web-based versions (Hosted on CMS and project websites)
 - Share tool with key organizations
- Related resources
 - How to Guide : Approaches to Integrating Primary Care Services into Behavioral Health Organizations.
 - Tip sheets to help organizations address workforce issues in behavioral health integration.

Questions for Participants

- In support of broad dissemination of the Behavioral Health Integration Capacity Assessment
 - Are there additional or companion resources that might be useful?
 - How might we make the BHICA widely accessible or reach a wide audience?
 - Are there other audiences that may find the BHICA or related resources helpful?

Audience Questions

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Thank You for Attending



- To access the online BHICA or download a paper version, visit <https://www.resourcesforintegratedcare.com/tool/bhica>
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 - Gretchen Nye at Gretchen.Nye1@cms.hhs.gov

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Resources for Integrated Care Website

We encourage you to explore www.ResourcesforIntegratedCare.com for a wide array of resources related to integrating care for Medicare-Medicaid enrollees:

Resources

Assessment tools
 Concept guides
 Topic-specific briefs
 Educational webinars

Topic Areas

Disability-Competent Care
 Self-Management Support
 Integrating Primary Care in Behavioral Health
 Care Coordination
 Workforce Development
 Navigation Services

Stakeholders

State Medicaid Agencies
 Health Plans
 Long-Term Services and Supports Providers
 Behavioral Health Providers

Individuals with...

Intellectual and developmental disabilities
 Physical disabilities
 Serious mental illness

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