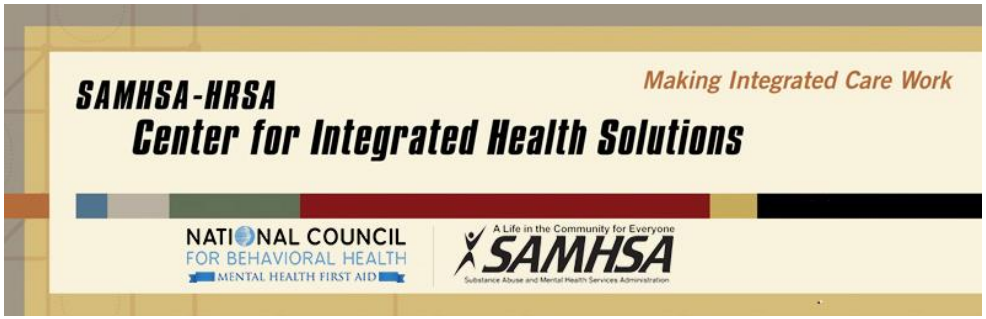
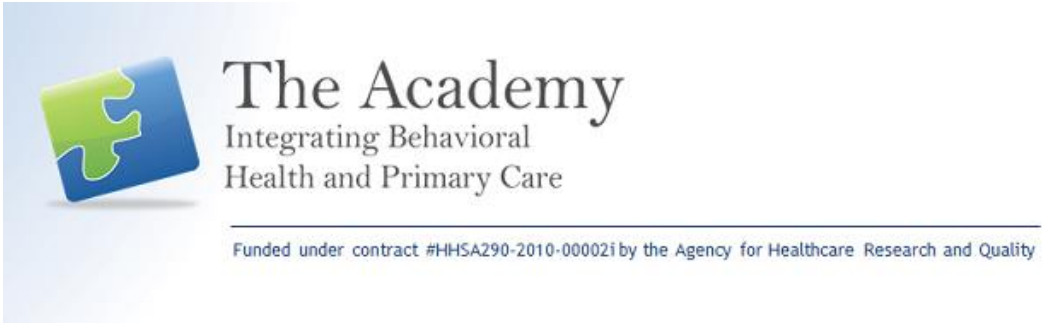
July 31, 2013

Integration Innovations: A Discussion with Federal Agencies (Webinar Part I of II)





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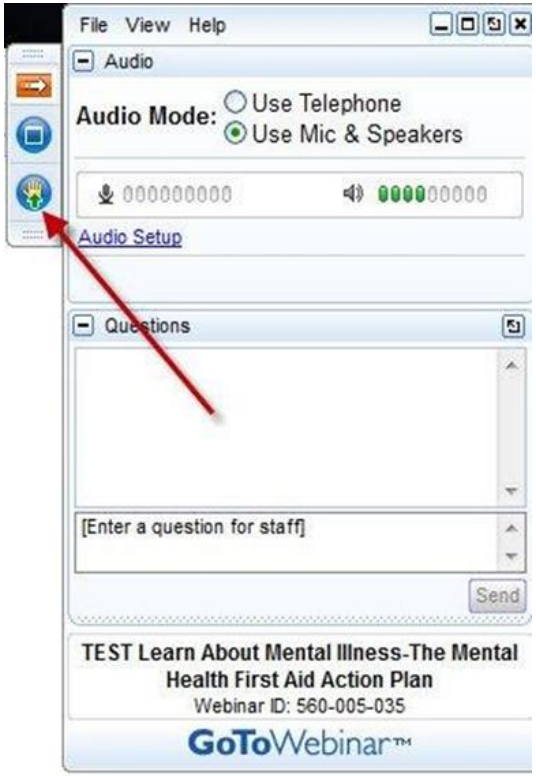

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The Academy
Integrating Behavioral
Health and Primary Care

Funded under contract #HHSA290-2010-00002i by the Agency for Healthcare Research and Quality

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

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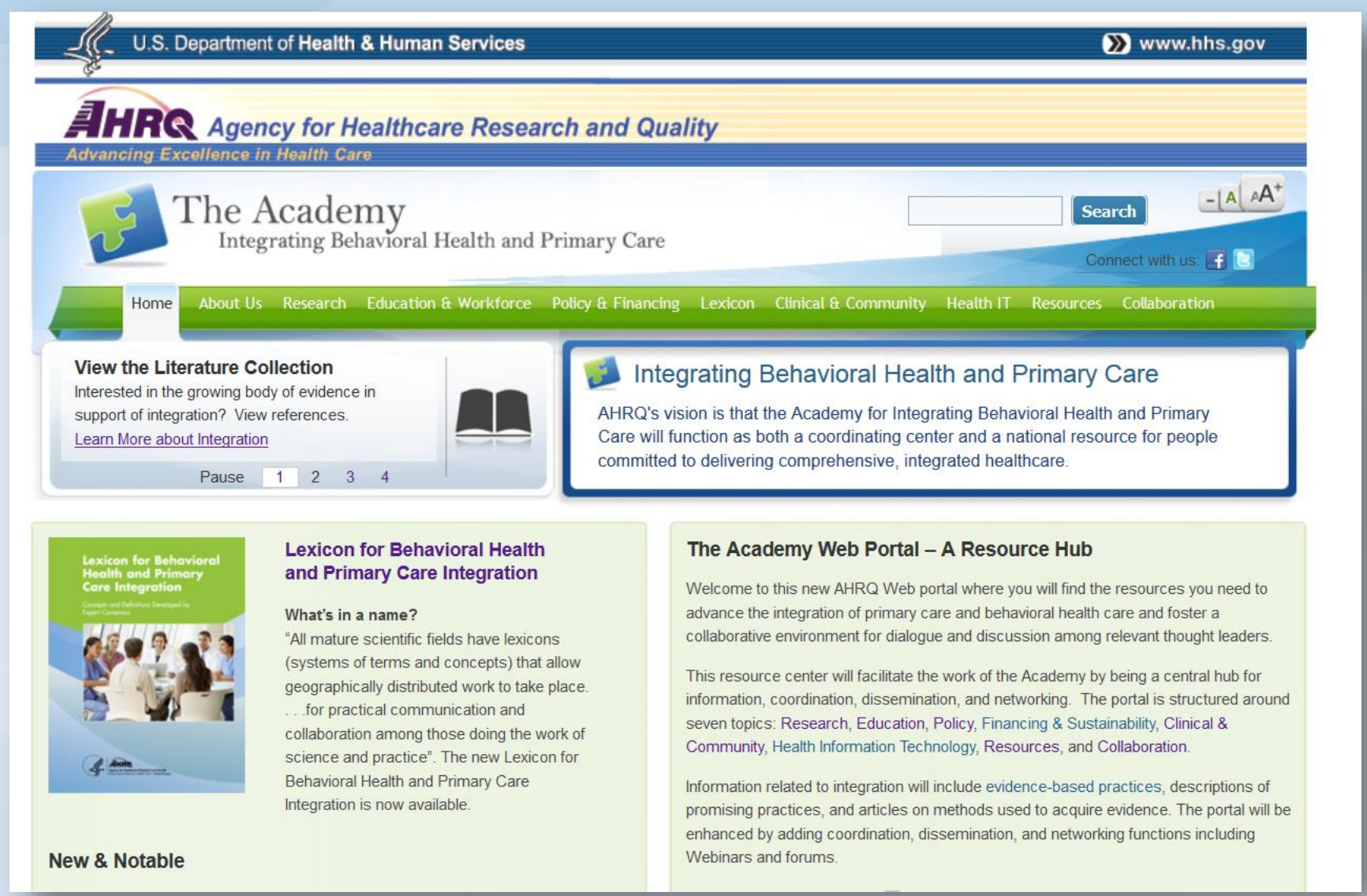

NATIONAL INTEGRATION ADVISORY COUNCIL http://integrationacademy.ahrq.gov/niacbios

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AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

The Academy
Integrating Behavioral Health and Primary Care

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Mission | The Academy Team

NIAC Bios | Project Team Bios

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National Integration Academy Council Bios

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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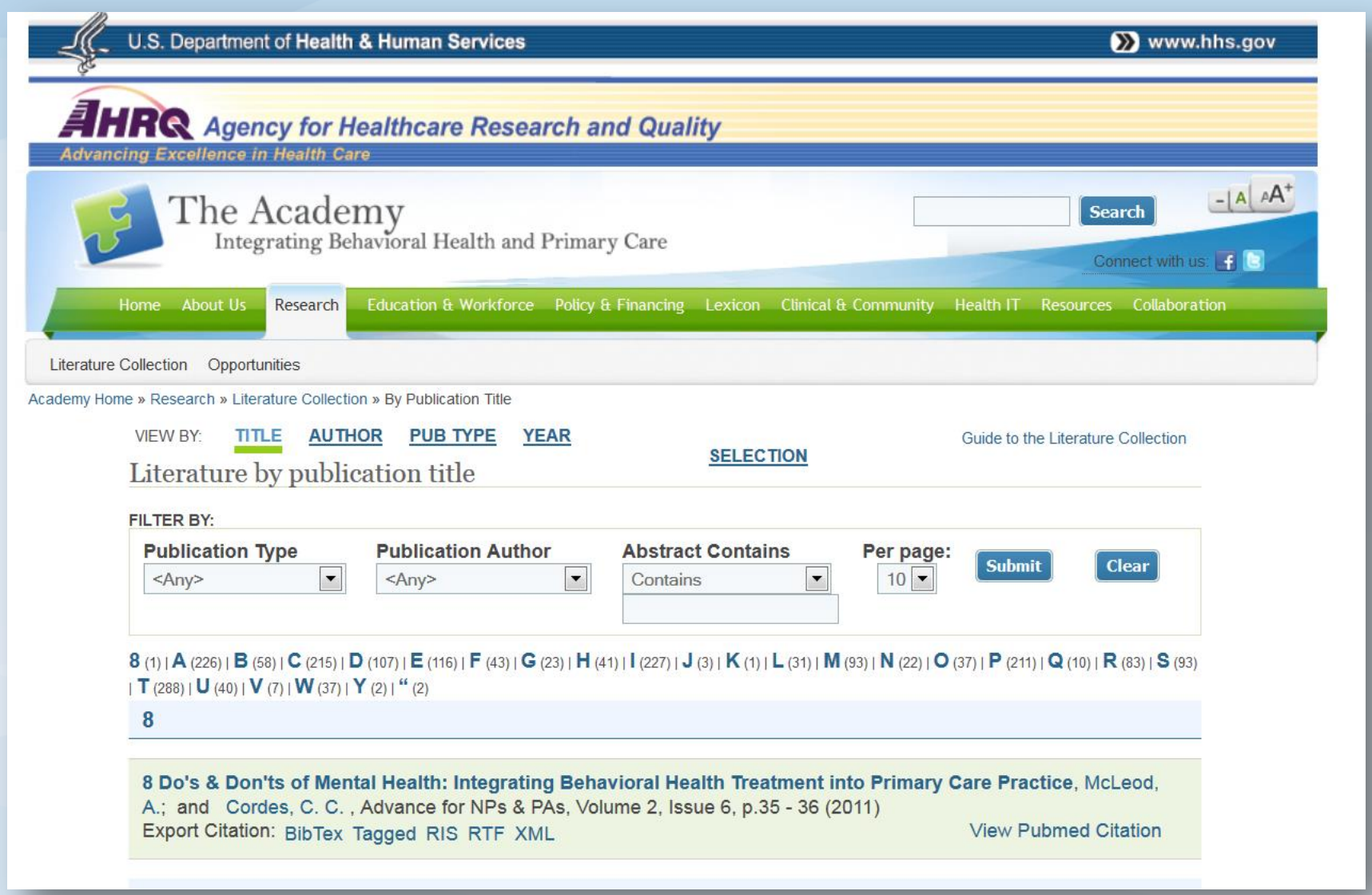
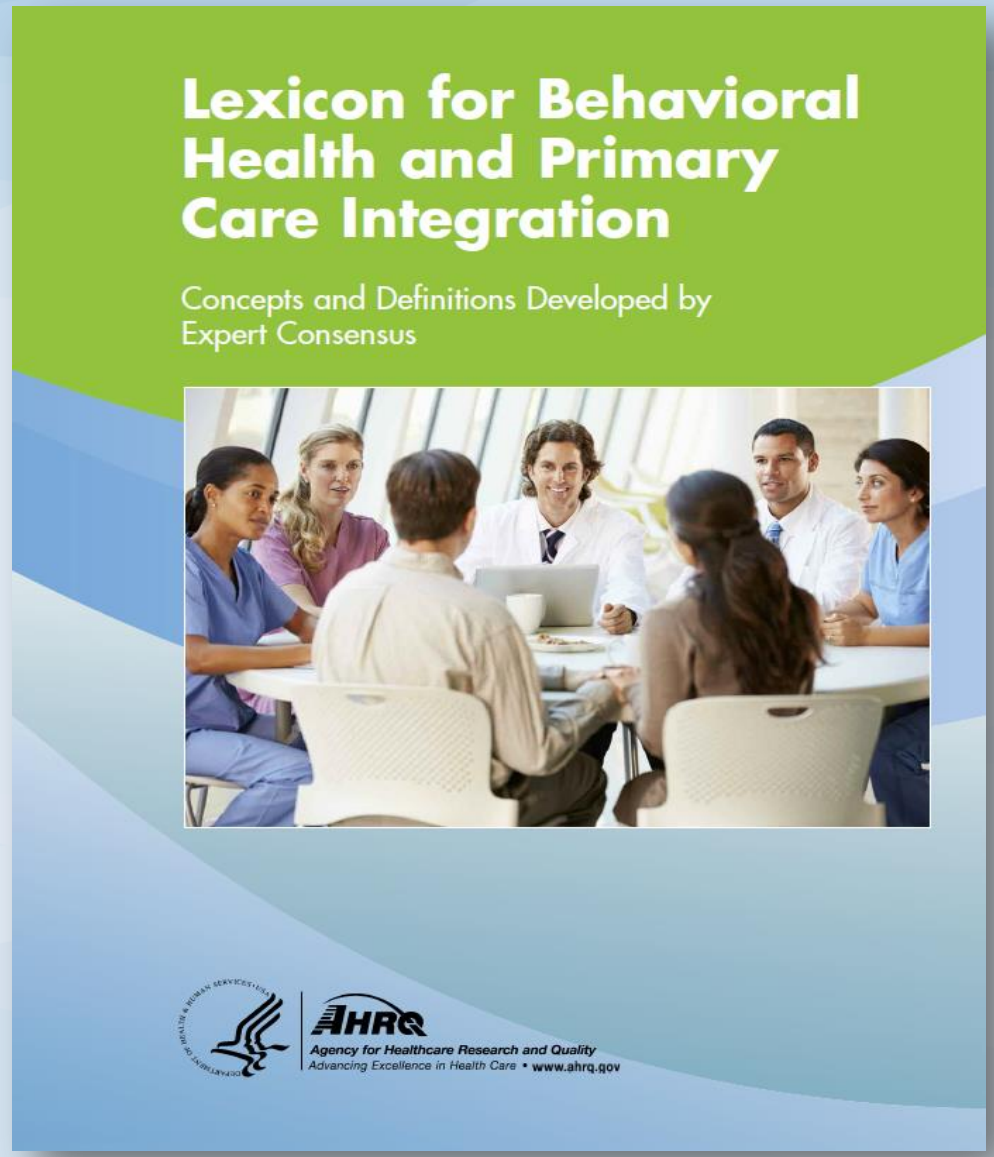


LEXICON http://integrationacademy.ahrq.gov/lexicon



- 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

Communities This Lexicon Intends To Unite:

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

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Atlas of Integrated Behavioral Health Quality Measures

IBHC Measures Atlas

Atlas of Integrated Behavioral Health Care Quality Measures (IBHC Measures Atlas)

Purpose

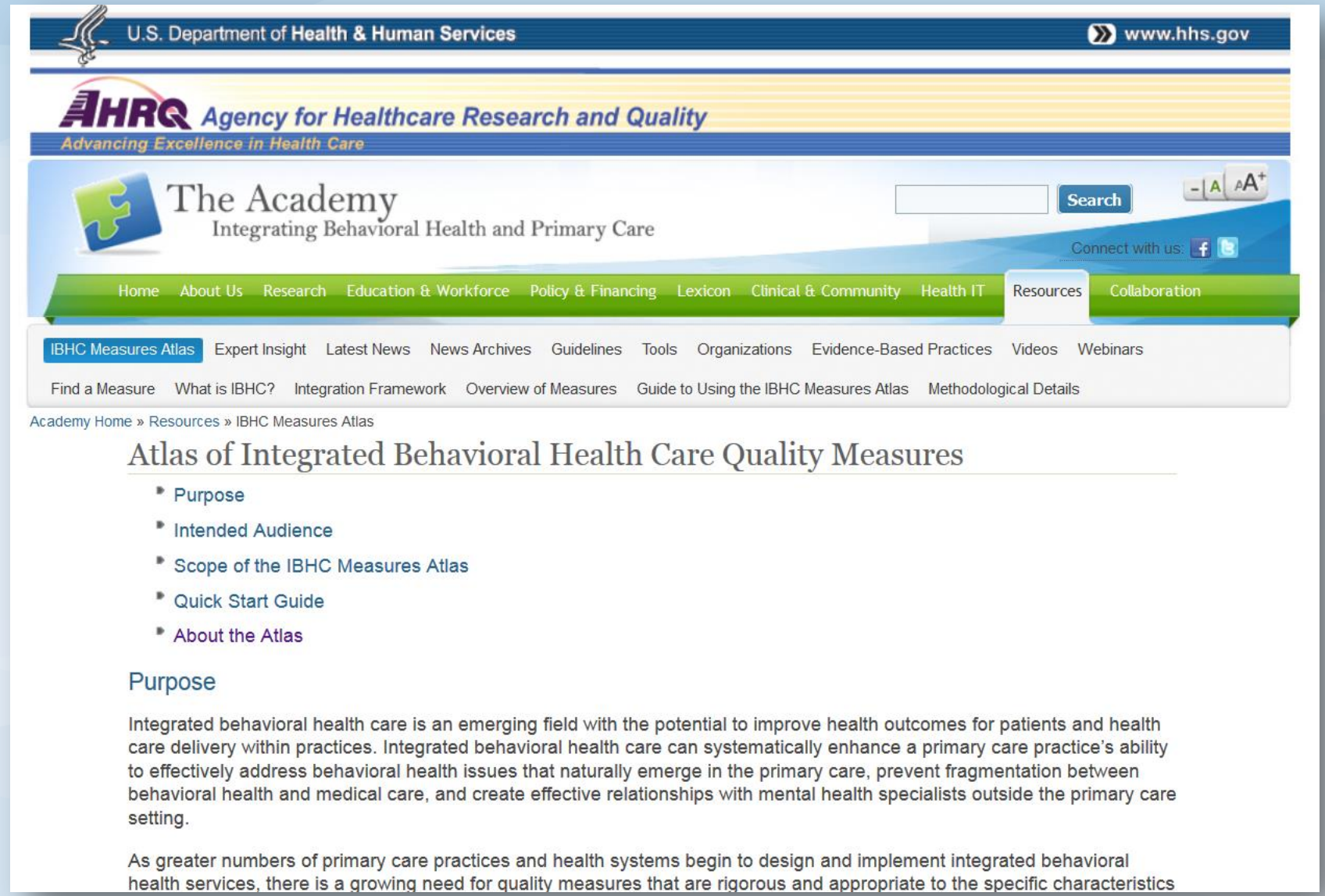
To support the field of integrated behavioral health care measurement by:

- 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

IBHC Measures Atlas: Atlas Home



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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SAMHSA-HRSA Center for Integrated Health Solutions

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

Prescribing for Addictions

Addiction Expert Calls for More Physician Training in Prescribing Buprenorphine

› Click here for details

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 specialty behavioral health or primary care provider settings.

› LEARN MORE

In the News

2011-10-03

Wall Street Journal highlights AHRQ campaign

Wall Street Journal highlighted AHRQ's new

2011-10-27

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

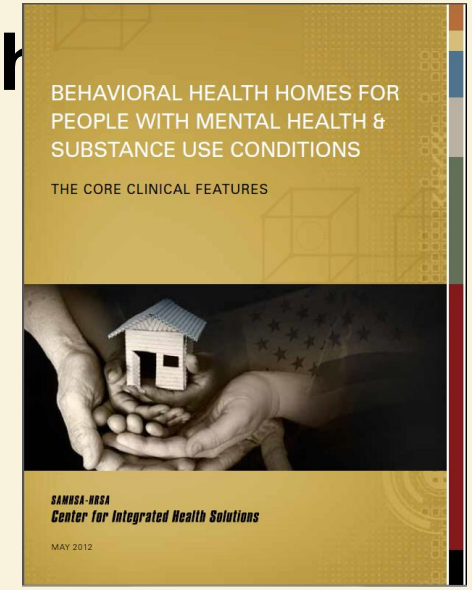
Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013 www.integration.SAMHSA.gov

SAMHSA-HRSA Center for Integrated Health Solutions

Moving Toward Behavioral Health 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 states 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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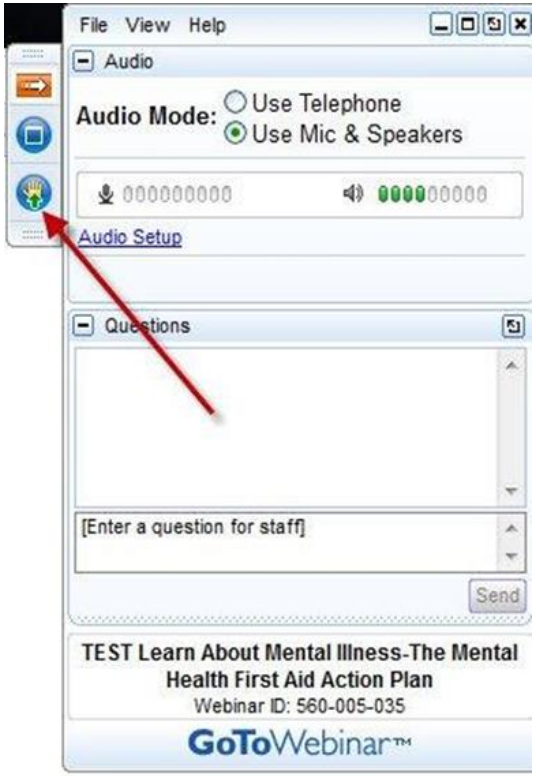

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