Preparing for Value-Based Payment in Behavioral Health and Primary Care 2018 Innovation Community

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HRSA Health Resources & Services Administration

SAMHSA Substance Abuse and Mental Health Services Administration

Setting the Stage: Today's Moderator

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HRSA Health Resources & Services Administration SAMHSA Substance Abuse and Mental Health Services Administration

Slides for today's webinar will be available on the CIHS website:

www.integration.samhsa.gov

Under About Us/Innovation Communities 2018

HRSA Health Resources & Services Administration SAMHSA Substance Abuse and Mental Health Services Administration

To participate

Use the chat box to communicate with other attendees

HRSA Health Resources & Services Administration SAMHSA Substance Abuse and Mental Health Services Administration

Disclaimer

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Setting the Stage: Today's Moderator

Mindy Klowden, MNM

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Order of Presentations Today

1. Terros Health
2. Community Care of West Virginia
3. Edgewater Health
4. Healthcare Alternatives systems, Inc.
5. Heartland Alliance Health
6. Horizon
7. Maine Behavioral Healthcare and MaineHealth
8. Nulton Diagnostic & Treatment Center
9. Piedmont Health
10. Rincon Family Services

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Order of Presentations Today

11. Terros Health
12. San Luis Valley Behavioral Health Group
13. Sequel Youth and Family Services
14. Rural Geriatric Integrated Behavioral Health and Primary Care Training Network
15. Volunteers of America
16. West Texas Centers

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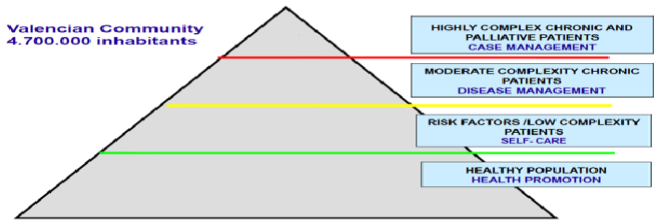
Risk Stratification Strategies
Terros Health

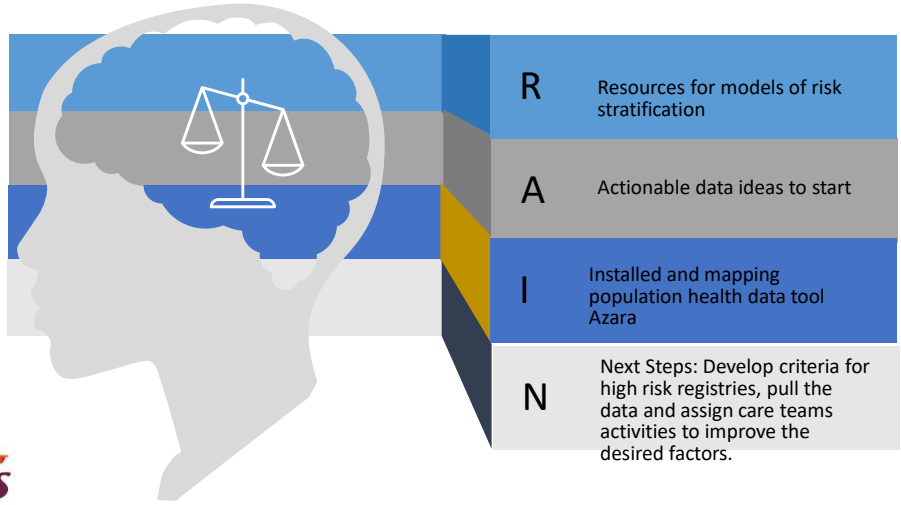
Jennifer Siozos
Karen Hoffman-Tepper
Dr. Brazie
Dr. Perea
Larry Villano
Saffron Wanger
Travis Eguchi
Mandek Aden
Julie Malloy

Terros Health Aim



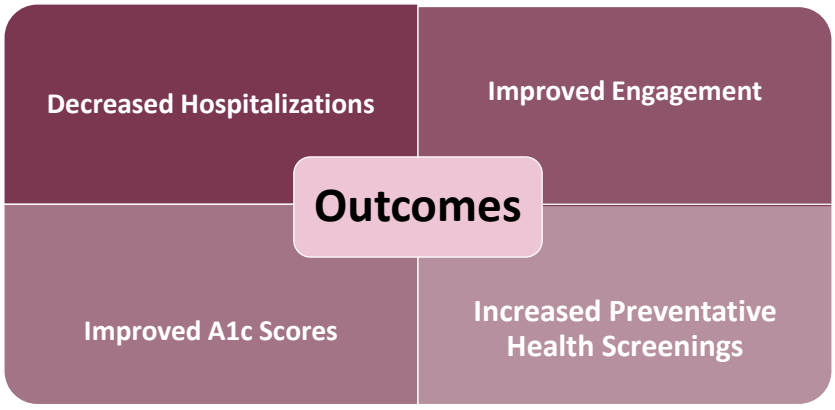
- Define and Develop Risk Stratification Criteria and Methods

What We Gained and Learned



Terros HEALTH

Desired Results for Implementation of Risk Registries



Terros HEALTH

Where Are We Headed: Next Steps

Building a risk stratification algorithm into our registries.

Produce registry reports for highest utilizers and for value-based contract priorities.

Developing streamlined processes for care teams to manage the registry reports in an efficient and meaningful way.

Terros HEALTH

VBC Learning Community Impact

- We learned from our expert consultant through sharing of resources and one on one consultation. Our learning as a team enabled us to work better within a more defined structure.
- The speakers offered good insights into culture change and organizational transitions to new models of care. This was shared with our Leadership Team and brought insights into some of the struggles we face in organizational shifting.

Terros HEALTH

Thank you Mindy and Learning Community for this valuable experience.

Terros HEALTH

Community Care of West Virginia

Telemedicine for Rural Integrated Primary Care and Behavioral Health

Breaking the payment barriers in a FQHC

Sarah Chouinard, MD
Kevin Junkins, MD

AIMS

- Spread the success of our behavioral health program across all CCWV FQHC sites
- Provide improved behavioral health access to Rural WV
- Identify barriers to payment for rural telemedicine
- Research actions taken by other states
- Weigh the cost/benefit of implementing telemedicine across sites
- Upon completion identify action steps we can take to change the payment landscape in WV

LESSONS LEARNED

- Participation in learning community through the National Council Communities, "Preparing for Value-Based Payment in BH and Primary Care Innovation Community."
- Payment is most flexible when bundled
- Payment through an ACO is effective for managing inpatients
- Payment in a PMPM model allows care to be delivered with less focus on billing according to BH practitioners' degrees
- Bundling allows for flexibility in program development and opportunity to customize interventions for best possible outcomes

RESULTS AND CONCLUSIONS

- Surveyed providers to assess the impact on patients
  - 85% of providers thought their patients would be receptive to receiving care through telemedicine
- Tested the use of technology to deliver telemedicine visits free of charge/billing
  - There were no barriers from a technologic standpoint
  - Well received by patients
- Established relationships with colleagues already to providing tele mental health services in West Virginia to assist in advocacy
- Surveyed other states' policies regarding tele-health
  - Identified states in which services are being utilized and billed for

GETTING INTO ACTION

- Join an ACO with a large health system to attempt to impact inpatient cost
- Meet with state law makers to discuss steps to improve access and remove barriers to care
- Meetings with individual MCO's regarding tele-health and bundling/value based payment
- Develop relationships with other telehealth providers in West Virginia
- Writing white paper to discuss this matter

Community Care of West Virginia

IMPACT

- Free/non-billable visits well received by patients
- Patient's with critical/urgent need benefiting from judicious use of non-billable tele health
- Leverage services provided in the school-based health centers
- Medicaid MCO willing to help advocate for expansion of services
- WV DHHR open to scheduling meeting to discuss pilot program

Providing Whole Person Care With a Value Based Approach

Edgewater Health-Janelle St. John, Eric Davidson, Jerrica Butler

edgewater health

The Aim for Participating in Value-Based Care Innovation Collaborative

- Purpose
  - Edgewater Health purpose of joining the Value-Based Care Innovation was to learn how to shift delivery care focus from volume to value by tracking patients care.
- Expectation
  - Our expectation was to be able to create delivery sets in order to establish a foundation for a value-based setting.
    - Our hopes were to create a work flow process to ensure clear lines of responsibility and to find and/or create a tracking tool that can effectively collect and analyze patient data.

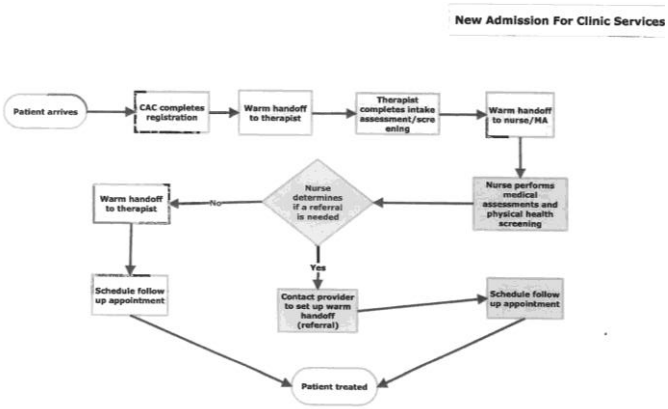
What Did We Learn

- Work Flow Process
  - Small interruptions outweigh the amount of “planned” work done in a single day.
  - Lower quality of care if a work flow that is clear and concise is not developed.
  - Even when you create a workflow hidden conflict and priorities of different roles arise.
- Tracking Tool
  - Challenge of coordinating care
  - A great deal of time is spent reconciling information without having the proper tools.

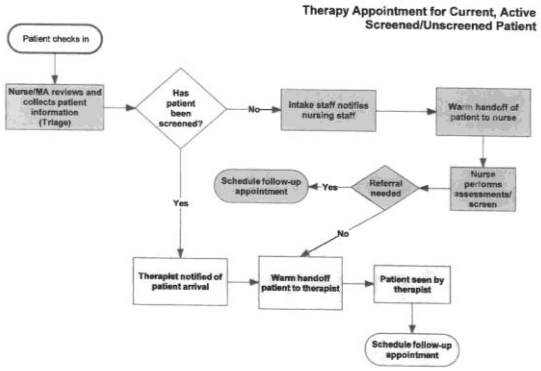
The Results

- As it stands we are modifying our current work flow plan on an on-going basis to reflect the challenges that the front line staff and clinicians have
- The tracking tool is a great success. We have been able to report a higher level of depression in our B.E.A.T. department (Brief Evaluation Assessment Team) than any other department within that location.

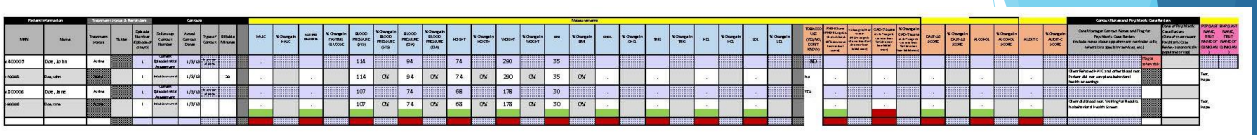
Workflow



Workflow



Tracking tool



Fields:

Name
Treatment Status
Tickler
"Episode Number
Actual Contact Dates T
Type of Contact
Billable Minutes
HA1C
% Change in HA1C
"FASTING GLUCOSE
% Change in FASTING GLUCOSE
BLOOD PRESSURE (SYS)
% Change in BLOOD PRESSURE (SYS)
BLOOD PRESSURE (DIA)
% Change in BLOOD PRESSURE (DIA)
HEIGHT %
Change in HEIGHT
WEIGHT
% Change in WEIGHT
"BMI
% Change in BMI
CHOL
% Change in CHOL
TRIG
% Change in TRIG
HDL
% Change in HDL
LDL
% Change in LDL
TOBACCO USE (YES, NO, Refuse to answer)
"PHQ-9 Score
"% Change in PHQ-9 score
"GAD-7 Score
"% Change in GAD-7 score
DAST-10 SCORE
% Change in DAST-10 SCORE
ALCOHOL
% Change in ALCOHOL SCORE
AUDIT C
% Change in AUDIT-C SCORE
"Care Manager Contact Notes and Flag for Psychiatric Case Review (Include notes about appointment reminder calls, referrals to specialty services, etc.)"
"Date of Psychiatric Case Review (Date of most recent Psychiatric Case Review automatically populates at top)"
PCP (LAST NAME, FIRST NAME OF CLINICIAN)
BHP (LAST NAME, FIRST NAME OF CLINICIAN)

Actions

- We will continue to edit our work flow processes to ensure success in providing quality and efficient care to our patients.
- We will begin to look at the trends of the results of the assessments being completed in order to review how clinicians are engaging with the client based on the level of scores provided.

The Impact on Patients and Edgewater Health

- The work flow processes has directed the team on how to deliver timely care that is consistent, reliable, and safe.
- The work flow processes creates a map and has been edited and will continued to be reviewed for revisions to include environmental factors such as workload, staff scheduled, and patient load.
  - This may also be a way to reduce high turnover from staff!
- We believe the impact of our changes will positively effect the patients by improving care and increasing access to information and/or care.

DATA DASHBOARD
HEALTHCARE ALTERNATIVES SYSTEMS, INC.

COLLEEN LENNON, MARIO ALVAREZ, & HALLE LEVY

WHAT WAS OUR AIM

- To learn more about value based payment and implementation
- To network and learn more about similar provider networks and organizations

WHAT DID WE LEARN

- What value based payments are and how other organizations are starting to implement them
- A need for more data collection, management, and distribution within our organization
- A need for more transparency and collaborative between departments and programs within our organization
- Buy-in from all departments and executive team members is crucial for implementation of new projects

WHAT WERE THE RESULTS

- We are still in the process of determining how to collect and distribute the data and the format/technology needed for a data dashboard available to all

ACTIONS/NEXT STEPS

- Identify technology/database for dashboard
- Begin to track identified data and quality measurements

WHAT WAS THE IMPACT

- For the organization, it made it very clear and public to the executive team and management staff the need for better tracking of data and quality measures, the need for transparency and collaboration between departments, and ways to grow and improve.
- For our participants, no impact as of yet, but the hope is with the dashboard we are able to improve quality of services, no show rates, waitlist times, successful discharge rates, etc. which will greatly benefit our participants.

Value-Based Payment
Getting the Word Out

HEARTLAND ALLIANCE HEALTH

What Was The Aim?

- **Inform staff of VBP so that they will encourage and influence positive change**
- **Develop a culture that embraces and showcases quality**
- **Help staff understand how the funding landscape is changing**

What Did We Learn?

- Most staff did not know what value based payment was
- Those who were aware did not think it would change the way they did their jobs
- Our Value Based Leaders do not have all the answers yet because it is only a cloud in the horizon now
- Data are key and foci need to change
- Systems and processes need to change
- Uniform quality dashboard needs to be developed

What Were the Results?

- Steps are underway to develop one EMR
- Developing a more robust quality program
- Encouraged conversations about quality and data in staff meetings
- Its bigger than we thought it would be!
- We're new to this type of risk and still not sure how to manage
- Questions about being a 'specialty' provider

What are the Next Steps?

- Part of Strategic Plan
- Continue pursuit of single health record
- Formalize and implement dashboard
- Improve efficiency around data access and service delivery
- Constant evaluation of environment (data, performance, impact)
- Integrate quality into every day conversations

HEARTLAND ALLIANCE
ENDING POVERTY

How Did This Impact Our Consumers?

- **Too early to tell**
- **Anticipate greater consumer engagement**
- **Improved health self-management**

Innovation Community Project

Horizon Behavioral Health – Lynchburg, VA	
Damien Cabezas *CEO*	
Andre McDaniel *COO & CFO*	**Manny Buabeng** *Director of Reimbursement & CQI*
Jennifer Switzer *Director, School-Based Services*	**Niki Arnold** *Billing Supervisor*
Judy Hedrick *Program Manager, Case Management*	**Rob Viohl** *Director, IT*
Krisann Taylor *CQI Data Analyst*	**Rose Lee** *Reimbursement Manager*

AIM

- Collaborate with MCOs to prepare for upcoming value-based negotiations
- Change the organization's culture to embrace data and value-based metrics

LEARNING

- Think like the MCOs
- Improve our documentation to meet changing standards (medical necessity)
- Improve our care coordination efforts (overall health)
- Move from volume-based to value-based services & reimbursement

EXPECTED RESULTS

- Improved overall health of our shared members
- Enhanced reporting of value-based outcome measures
- Preferred-Provider status
- Maximize reimbursement

ACTIONS

- Implement value-based incentives contracted by one of our MCOs
- Implement Finance measures and controls to ready our organization for value-based payment approaches.
- Develop a methodology to measure consumer satisfaction on an ongoing basis

IMPACT

Our meetings with MCOs have changed the way we operate.

Leadership must drive cultural change.

HORIZON
www.horizonbh.org

Maine Behavioral Healthcare and MaineHealth VBP Project: Investigating our System Potential

Team Members:

Robert Fulton, MD – Primary Care provider

Kathy Bubar, Director of the Pride Program (Bi-directional integration program)

Victoria Hynes, LCSW – Pride program clinician

Stacey Ouellette, Director Behavioral Health Integration program

Randy Morrison, Director of Peer Services

Mary Jean Mork, VP of Integrated Programming

MaineHealth

Maine Behavioral Healthcare
MaineHealth

Project Aim

Given that almost 100% of the primary care practices in the MaineHealth system have integrated behavioral health clinicians (BHI), and given that most of them are working in Epic we planned to:

1. Begin to evaluate what data is available in Epic to indicate impact of BHI
2. Research other data driven projects by our ACO for potential replication
3. Identify a measure to be used to evaluate impact
4. Develop an ongoing process for evaluation
5. Using this data – begin to measure the impact of BHI

MaineHealth

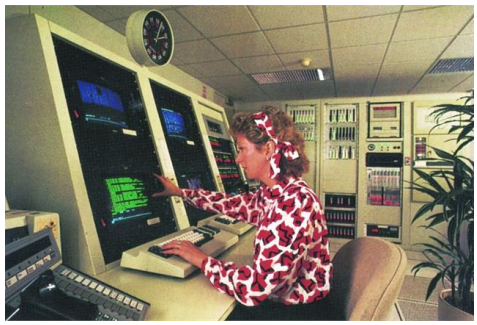
Maine Behavioral Healthcare
MaineHealth

What we learned: "Start where you are…

- The challenge of getting data!
- The challenge of finding people to help us get data!
- The benefit of having a primary care provider on the team!

Changes the results: …Use what you have….

- Rather than doing something new and different – what could we use that was already created?
- Using the already created Diabetes registry to focus on PHQ scores and BHI intervention



Actions: …Do what you can."

- Review the Diabetes registry with Epic physician leader
- What does it tell us? How can we use it?

Impact

- Kick-start to using data to evaluate value of BHI
- Using chronic disease registries to evaluate value of BHI
- Involvement of primary care leadership in evaluating value of BHI
- We learned what we know and WHAT WE DON'T KNOW…and where to go next

VBP @ NDTC

NULTON DIAGNOSTIC & TREATMENT CENTER | TIMOTHY CUSTER

AIM

- General Understanding of VBP in preparation for VBP contracting.
- Models (P4P, Bundled, Shared Risk, Full Risk, etc)
- Data/Outcomes- Who, What, Where, When, Why
- Implementation- How have others been successful
- Behavioral Health Home Contract

Learning Collaborative Implementation

- Understanding what the payer/contract was looking for related to Outcomes and how it relates Payment(ex, PCP follow up)
- Data Integration to allow exporting of information for Audits
- Agency "buy in" (EMR, Clinicians, Administration, Billing, Compliance, Quality Improvement Team)
- Continued use of provided resources for future contracting (articles, data, models)

Action leads to Results

- Improved Forms that now gather needed data (SHOT, WHOOT, PCP contacts, Wellness Plans)
- Team Collaboration/Understanding (Ex. Clinicians: understanding of why changes are occurring, form development for easy workflow/completion, how contract aims to help patients)
- Improved from 2 areas of deficiency in Q3 2017 to 0 areas in Q4 2017
- Result- Full payment for Q4 2017 !!!

Next Steps

- Continued review with Quality Improvement Team
  - Monthly QIT meetings
  - Review of Audit results and how we can continue improve scores/fidelity to model.
  - Patient Satisfaction surveys- how are patients responding to new initiatives/ treatment model
  - Create Client Portal and Client Dashboards (Ex. BMI, Medications, etc)

Impact

- BHH Program participation increased - from 20% of recommended clients being assessed in Q1 2017, to over 90% assessed in Feb 2018
- Improved Integrated Care/Communication with PCPs. Meeting follow up standards for more than 80% of clients involved with BHH model
- Decision to have more staff trained in the BHH model. Availability of Model across agency, not just with members of BHH payer

PSYCHIATRIC COLLABORATION OF CARE PILOT

Team Members: Elizabeth Childs, Lynn Salazar-Wadford, Marni Holder

AIM OF PARTICIPATION IN COLLABORATIVE

- Learn overall concepts of Value Based Behavioral Health
- Learn about specific measures
- Understand various payment models
- Hear from other organizations who are engaged in value based behavioral health models.

WHAT DID YOU LEARN?

- Various models of value based care
- Specific HEDIS measures which could be utilized in our organization
- Increased our understanding of population management and how this can be utilized in integrated setting

RESULTS

- Identified and studied the psychiatric collaboration of care model as a value based care target initiative.
- 3/2018 - Implemented new workflow and documentation process for this model at one community health center site.
- Registry data is being collected, too early to analyze results.

IMPACT

- Increased interdisciplinary team collaboration with population targeted.
- Excitement from team about better addressing needs in high risk/high-utilizer population.
- Model will be adapted based on on-going data collection.

Rincon Family Services: Valuing Our Care

Dr. Applewhite, Necole, Beth & Michaela

Goals of Participation

- Learn more about Values Based Payment Models
- Create a project for one program to move forward in implementing at least one criteria of Values Based Payment

Progress toward Goals

✓ Learn more about Values Based Payment Models
- Webinars & Individual coaching
- Resources on website and Individual research

✓ Create a project for one program to move forward in implementing at least one criteria of Values Based Payment
- Group discussions
- Research with Electronic Health Records

Results

- Identification of Barriers
  - No official requirements from IL Medicaid
    - Lack of incentive to make changes in advance
    - Concern over changing only to have to change again
  - General lack of consensus of Values Based Payment options for Community Mental Health Clinics
  - Lack of funding to customize Electronic Health Record Systems
- Identification of desire
  - Language of Values Based Payment is more common
  - Organization leadership support in moving forward

Next Steps

- Continue Learning
  - About organizational readiness throughout other programs
  - About Illinois Medicaid guidelines
- Implementation
  - Educate more staff on Values Based Payment
  - At least one HEDIS measure for Mental Health

Impact

- More awareness
- More knowledge
- More commitment to change

Thank you!

SAN LUIS VALLEY
Behavioral Health Group
Dedicated to Hope, Healing and Recovery

Engagement Improvement Project

Value Based Payment

Data, Data, Data

- Access to data – **we have a lot!**
- What do we do with the data and why
- Do we all understand the data
- We choose to pull data to track our engagement success on a weekly basis

Change

"We do what we know until we learn to do something better"

Now What!

Sequel Youth and Family Services (SYFS)

Hilliary Mahler, Michelle Fenelon, Mike McFarland, Susan Cosgrove

What was the ***aim*** for participating? (rationale for joining or what want to achieve?)

- To understand what current evidenced based practices are being used, what value based indicators and specific contract standards are current in SYFS behavioral health and primary care facilities.
- To understand the different levels that exist when truly entering into a Value Based Payment agreement as SYFS enters into various Child Welfare System redesign initiatives.
- To become sound in the areas of IT, marketing/research, data management and basic programming as it relates to Value Based Payment agreements.

What did you ***learn***? (activities implement? What resources valuable and why?)

- Woodward Academy Foster Group Care Facility uses Meaningful Use (MU) in nursing department for several years
- Focus is on Woodward Academy – Foster Group Care Facility currently under contract by State of Iowa with four Performance Measures
  - Performance Measure 1 – Length of Stay
  - Performance Measure 2 – Return to Group Care for CINA Youth
  - Performance Measure 3 – Recidivism of children Adjudicated for Delinquent Acts
  - Performance Measure 4 – Discharge to a Family-Like Setting

If you made changes what were the ***results***? (Did you see improvements? Data?)

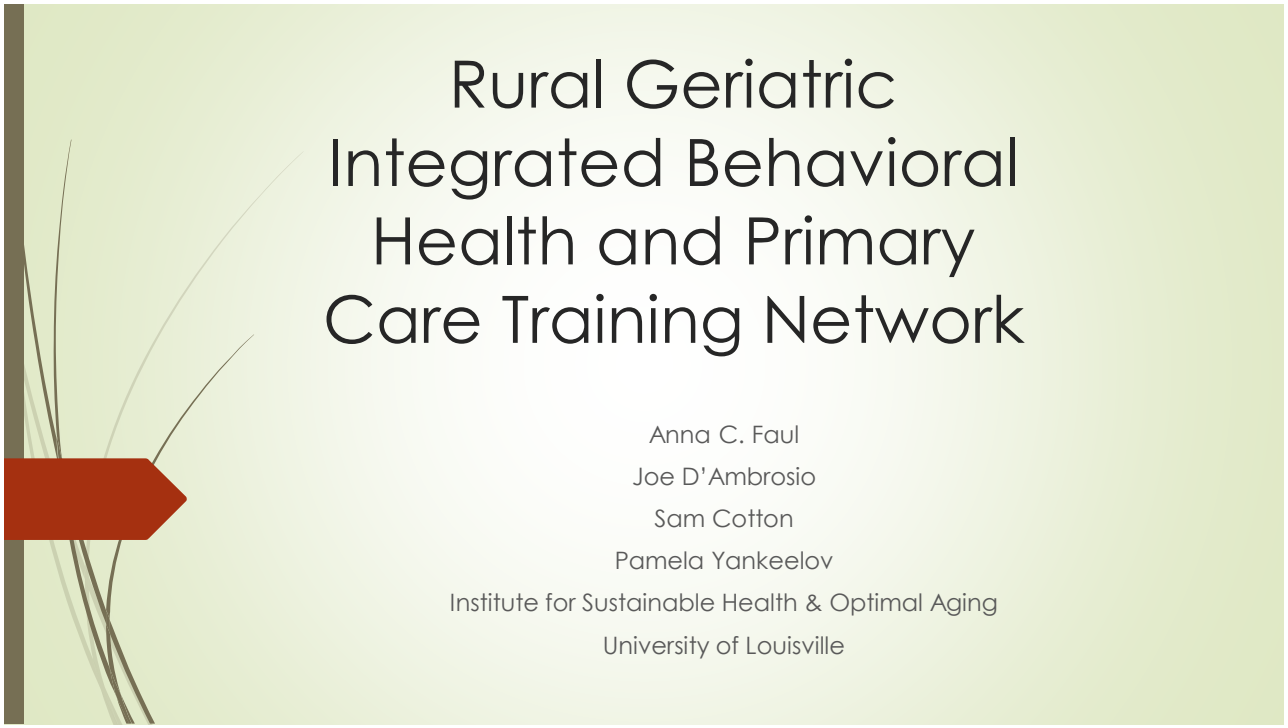
- Woodward Academy made changes based on the following slide with reference to performance measures.
- Need for infrastructure costs to conduct quality assurance measures to show outcomes.
- One change was the need to stay connected with discharged clients to ensure we could track the outcomes.
- A change when using the data is to ensure that we are using the treatment methodology to impact the specific client's needs based on success post program encounter.

What ***actions*** will you take next as a result of participating in this Innovation Community?

- Continue to research payer and consumer identified value points
- Continue to research evidenced based treatment modalities
- Connect with other providers using value based contracting/explore pros and cons

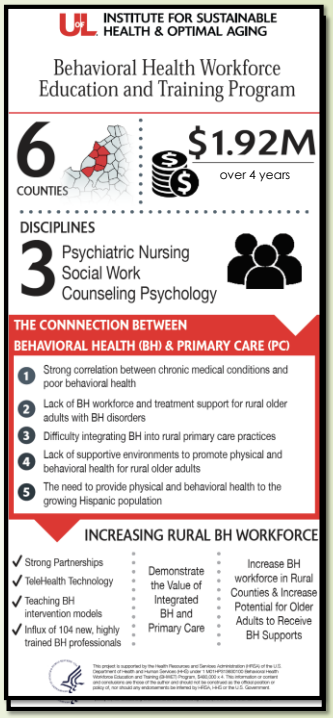
How did this project ***impact*** your customers and your organization?

- Woodward Academy has been impacted in numerous ways by four performance measures: - not sure what to put here peeps?
  - Performance Measure 1 – Length of Stay (shorter length of stay)
  - Performance Measure 2 – Return to Group Care for CINA Youth
  - Performance Measure 3 – Recidivism of children Adjudicated for Delinquent Acts
  - Performance Measure 4 – Discharge to a Family-Like Setting



Participation Rationale

- Needed to be informed in value based payment models, like MIPS or Advanced APMs to make case to PCPs for their involvement



Value added of Innovation Community

- Better handle on the Value Based Payment Models
- Realized grant-selected PC practices were participating in MIPS but are not participating in Advanced APMs
- Greater awareness of BH CPT codes including:
  - Collaborative Care Model
  - Behavioral Health Integration
  - Chronic Care Management Codes
- But still are hungry for more knowledge

Results?

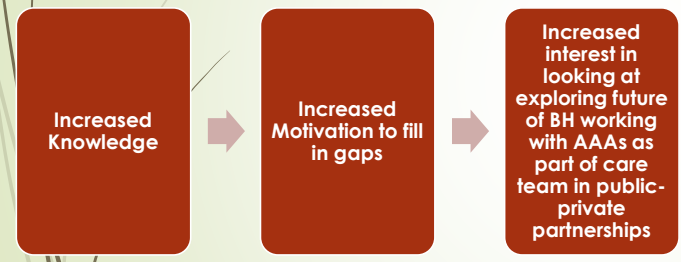
- Better able to collaborate with our QIO/QIN due to a shared language
- Better equipped to include in training of our BHWET students
  - Will incorporate in our online learning modules, our weekly workshops, in Project ECHO (tele-mentoring & case-based learning) monthly workshops, etc
- Better equipped to discuss the benefits of CMS value based payment model, MIPS and APMs with PC offices

Future Action

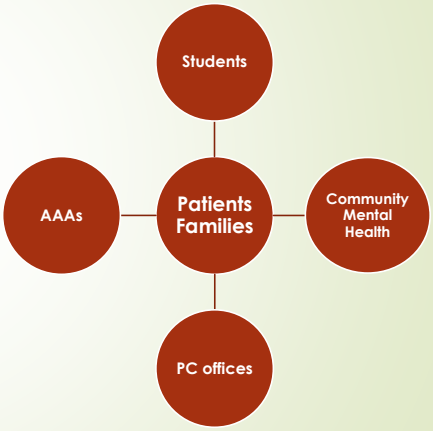
- Value based payment model language should not be a "one and done" workshop or training activity
- Include on a quarterly basis in our training schedule
- Continue to work with our QIO/QIN

Impact on customers/organization

Executive Leadership on BHWET grant:



Impact on "customers" yet to be determined:



Integrated Care Services

PREPARING FOR VALUE-BASED PAYMENT IN BEHAVIORAL HEALTH AND PRIMARY CARE

SAMHSA-HRSA Center for Integrated Health Solutions
National Council for Behavioral Health

Brian Byrd, MPH
Executive Vice President – Innovation and New Business Development
Tel: 318.429.6973
Email: Brian.Byrd@voanorthla.org

Integrated Care Services

Project Aim:

Volunteers of America North Louisiana (VOANLA) is seeking to add new "integrated care services" to our portfolio of programs in both north and central Louisiana in response to the changing direction of the healthcare landscape in our state. Integrated health care is the systematic coordination of physical and behavioral health care.

- Build on the strengths of housing, clinical care, and other supports
- Improve the "Triple Aim" of better care, better health, and lower costs sought by our funding sources and Louisiana Department of Health
- Integration of services provides a cohesive service delivery system for those we serve
- Maximize revenue potential through Medicare service codes of Chronic Care Management and BHI

Internal Market Analysis Results

VOANLA currently serves a high number of individuals who have multiple chronic conditions in a wide variety of programs who have Medicare or are dual eligibles

Data

Program Area	Medicare or MC/Medicaid
Housing/VA Programs	54
Behavioral Health	30
Ballington Center	35-40
South Point Place	45

Sample of those currently served by VOANLA identified a market potential of**164** individuals who have Medicare or are dual eligibles and assuming a +/- 5% standard deviation, our internal market potential could be estimated from **150 to 180** individuals who would benefit from integrated care.

Changes and Enhancements: Next Steps

Need to define further the information collected on the individuals served to determine potential internal market.

Data:

- Type of Benefits: Medicare, Dual Eligible, and Medicaid only
- Determine number of chronic conditions our existing caseloads
- Services: Type of services provided and need for additional
- Identify our main existing referral sources and primary care providers

Adapt

Services:

- Using Four Quadrant Clinical Integration Model, determine level of integration based on our current programs, services, and needs of our target populations
- Identify partnership opportunities with FQHC's, hospital systems, and primary care providers
- Determine managed care organizations to pursue enhanced services under our existing value based care contracts AND pursue new value based care contracted services with other high need-high cost populations
- Identify within our existing programs and sites that would allow for service delivery
- Determine costs to build out or modify space to allow integration of primary care
- Research opportunities to scale up PC/BH Integration

Foundations for Alternative Payment Models

West Texas Centers
Jesse T. Vick, CPA
Big Spring, Texas

Why did we participate?

- Learn the varied types of payment models
- Get feedback on our plans
- Strengthen our negotiating position

What did we learn?

- Improving communication channels with staff lays the foundation for change
- Modifying performance evaluations underscores our commitment to change
- Changing organization culture is a difficulty shared by many

What results did we achieve?

- Developed a timeline for implementation
- Gained support from leadership
- Reviewed all company job descriptions
- Adopted a *Balanced Scorecard* format for performance evaluations

What actions will we take next?

- Roll-out organization intranet
- Educate leadership on *Balanced Scorecard* over the course of several months
- Align staff and organization performance measures

How were we impacted?

- Increased commitment from leadership
- Increased understanding of alternative payment models
- Improved negotiating position

SAMHSA-HRSA Center for Integrated Health Solutions

WHO WE ARE

The **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** is a national training and technical assistance center dedicated to the planning and development of **integration of primary and behavioral health care** for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider Settings across the country.

CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), and is run by the National Council for Behavioral Health, the unifying voice of America's healthcare organizations that deliver mental health and addictions treatment and services.

HRSA Health Resources & Services Administration SAMHSA Substance Abuse and Mental Health Services Administration

CIHS News and Resources

Visit

www.integration.samhsa.gov

or e-mail

integration@thenationalcouncil.org

Free consultation on any integration-related topic!

HRSA Health Resources & Services Administration SAMHSA Substance Abuse and Mental Health Services Administration

Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

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