An Integrated Care Playbook:

Lessons from the Behavioral Health-Primary Care Integration Learning Collaborative

Health & Medicine
POLICY RESEARCH GROUP

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Executive Summary

Health & Medicine Policy Research Group's Center for Long-Term Care Reform started the Behavioral Health-Primary Care Integration Learning Collaborative in 2015 to guide local advocacy and facilitate practice-level change to improve the lives of people with mental illness and substance use disorder. The Center's work in aging and disability policy had often brought us together with Illinois behavioral health advocates and we consulted with those allies before launching the Learning Collaborative. Not surprisingly, a priority for most behavioral health advocates was eliminating the disparities in outcomes for people with mental illness and substance use disorders—especially the startling 25 year disparity in life expectancy. We also heard advocates, providers, and people with lived experience describe the fragmentation of behavioral health and physical health, and primary care in particular, as a leading cause of those poor outcomes. Behavioral health symptoms themselves may impair an individual's ability to carry out life activities, including managing chronic health conditions. But the barriers to access and breakdowns in communication and coordination between primary care and behavioral health providers is a symptom of the system's failure as well. We will not address an individual's ability to manage complex physical and behavioral health conditions if we do not improve providers' ability to collaborate in delivering integrated care.

We launched the Behavioral Health-Primary Care Integration Learning Collaborative to contribute to the goal of improving integrated care. After recruiting a group representing behavioral health and primary care providers, payers, and people with lived experience, we set out to identify concrete ways that we could make an impact on behavioral health integration. The focus of our early work was on establishing criteria for integration that laid the foundation for a common analysis of problems and solutions, identifying gaps in implementing those criteria in practice, and developing practice-level solutions. In the past year the Learning Collaborative's three Workgroups have been exploring those ideas and testing ways to improve hospital-to-community transitions, digging deeper into strategies for financial sustainability, and confronting the systems-level demands of electronic data exchange.

This Playbook shares the lessons from building and operating a Learning Collaborative and from our three Workgroups. We hope that others can use these as tools to launch or enhance quality improvement and collaborative learning projects.

Key Lessons

Building a Team

- **Include a state-wide organization.** Even for a project that is largely focused on the Chicago-area, having at least one member representing a state-wide organization has been invaluable. Like most of the Learning Collaborative members, we reached out to the Community Behavioral Healthcare Association (CBHA), a state-wide provider group, based on their long-standing relationship with Health & Medicine staff. This prior experience working together and CBHA's extensive connections to providers, policy makers, and content experts were vital foundations for the work of the Learning Collaborative.
- **Have the difficult discussions about project scope early.** Learning collaboratives tend to be hopeful and ambitious. Narrowing their work to a manageable scope and achievable goals is difficult, but necessary. Although many of our Learning Collaborative members were passionate about child and adolescent behavioral health, for example, we decided together to focus on adults with moderate to high-need behavioral health conditions.
- **Set group agreements and commitments for participation.** To ensure consistent participation, ask member organizations to name two individuals who will attend all learning events. Written group agreements and meeting 'ground rules' should also encourage open, honest dialogue and active engagement with decision-making.

- **Compensate members for their time and effort.** Participating in a learning collaborative takes time and makes frequent demands on member organizations to attend meetings and webinars, complete surveys, collect data, and contribute to workgroups and research. Funding to support stipends to cover the costs of participating, along with flexibility in offering a variety of methods for learning – in-person, webinars, and email exchange—is crucial for a learning collaborative.
- **Set-up a Planning Committee.** In order to help move the work of a learning collaborative forward without overtaxing the time of every participant, recruit a core group of members who have the capacity to devote the time to serving on a Planning Committee. This body can be largely self-selected, but it is important to have a balance of experience and expertise to guide the larger Collaborative.
- **Engage people with lived experience from the very beginning.** Following the disability rights movement's dictum "nothing about us without us," any group addressing the health care of a specific population must include members of that population itself. This voice is irreplaceable on a learning collaborative and teaches other members new ways of looking at old problems. For example, we discussed the fact that 10% of Medicaid recipients with behavioral health conditions account for 72% of behavioral health expenditures. For a payer, the disproportionate expenditure, together with disappointing outcomes, represents a failure to deploy their financial resources for the best interests of their members. For a person with lived experience, however, this articulation of the purpose of integration may appear to make the person herself the problem, as the generator of unsustainable costs. Bringing those voices together and providing space to listen and learn from one another helps build the spirit of trust and mutual collaboration that is necessary for integrated care to succeed.

Common Analysis of Problems and Solutions

- **Create a consensus definition for the goal of the learning collaborative.** We adapted a definition of integrated behavioral health and primary care from the National Integration Academy Council and provided multiple opportunities for Learning Collaborative members to refine the language during in-person meetings, on webinars, and through email and phone conversations. In the end, everyone agreed on a single definition to which we could refer back to refocus our work as we moved forward:

  "Care that results from a practice team of primary care and behavioral health clinicians—who partner with community-based and wraparound service providers—which may include co-location and electronic health records (EHRs) sharing data, 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 physical health, mental health, and substance use disorder conditions, health behaviors (including their contribution to chronic medical illness), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

- **Recognize and adapt to the changing policy context for integration.** Improving on-the-ground implementation of managed care was a clear priority for the Behavioral Health-Primary Care Learning Collaborative, as providers were still adapting to the rapid expansion of Medicaid managed care in Illinois when we started in 2015. Operating throughout 2016 and 2017 meant that Illinois' budget crisis was also an enormous part of the policy background for the Learning Collaborative's work. State-level plans for Integrated Health Homes, expansion of telehealth and telepsychiatry, and an ambitious 1115 waiver to expand access to substance use disorder treatment are now all coming to fruition. Understanding the impact of policy changes on our work and being prepared to change plans, but also to advocate for the policy needs of integrated care, have been key components of operating a flexible and impactful Learning Collaborative.
- **Define criteria to set more granular parameters for the Learning Collaborative's Work.** After defining integrated behavioral health and primary care, agreeing on a scope for the Learning Collaborative's

work, and establishing a common understanding of the policy context, we defined, interrogated, and revised six integration criteria. These are the six elements without which a health care practice cannot be considered integrated, according to our definition. We developed the Six Criteria without expecting that any existing practice completely fulfills every one of them. Rather, we regarded each criteria as a value that practices should be striving to achieve and continually improve. The criteria we chose further define the goal of integration and reflect flexible strategies that interconnect with one other, and when conducted in harmony create the highest-performing integrated practice:

> *An integrated practice must be person-centered, evidence-based, and financially sustainable and provide comprehensive core services with clear workforce and technology standards.*

Ongoing Work of the Behavioral Health-Primary Care Integration Learning Collaborative

Establishing the Six Criteria allowed Learning Collaborative members to systematically evaluate their own practices and those of outside models, such as Missouri's Health Homes program, and identify promising interventions, major gaps, and potential solutions. The group prioritized three areas for more focused study: hospital transitional care; financial sustainability; and data exchange. A Data Exchange Workgroup is investigating the current state of health information exchange and behavioral health quality measures and developing policy recommendations to support implementation of best practices. Feasibility studies were chosen to take a deeper dive into Financial Sustainability and Hospital Transitions. The study designs were meant to answer "Can it work?" and thus set the stage for future research that can evaluate efficacy.

Workgroups

1. Hospital Transitional Care

The Problem

Hospitalization for behavioral health crisis is a key pivot point in integrated care, and an area in urgent need of process improvement. Connecting people to primary care after a hospital discharge, however, was a serious challenge and this gap in care coordination clearly interferes with the goal of integrated care. Sinai Health System and Lutheran Social Services of Illinois (LSSI) volunteered to serve as the participating sites for the Hospital Transitional Care Workgroup's feasibility study. Because Sinai and LSSI were both operating innovative programs to connect hospital patients to community-based behavioral health services, the workgroup agreed that the most urgent need was to improve post-hospital linkage to primary care. If the study successfully identifies best practices in coordinating primary care follow-up after hospital discharge, then they can be incorporated into Sinai and Swedish Covenant Hospital and LSSI's existing processes for behavioral health follow-up, resulting in a powerful advance in behavioral health integration.

What We Learned

Importantly, the Workgroup was neither looking for temporary workarounds to transitional care challenges nor for a strict evaluation of a specific intervention. Rather, we want to examine transitional care processes—what happens on the unit, after discharge, and at follow-up appointments—and track specific metrics that guide real-time adjustments of those processes and, in the end, find best practices that can be disseminated and replicated. Best practices from the study will address communication between hospital and MCO care coordination staff to identify the patient's assessed risk and primary care provider's relationship, communication of transition records between hospitals and primary care, and the actual follow-up with a post-discharge PCP appointment. This study will launch Summer 2018.

2. Financial Sustainability

<u>The Problem</u>

Delivering behavioral health and primary care services in an integrated setting is resource intensive, requiring more time with health care professionals to develop trust, rapport, and capacity to coordinate between the distinct providers who often co-locate with separate EMRs, separate funding streams, and separate governing/operating structures. This also requires more care planning, care coordination, and case consultation, which can be disrupted by hospitalizations and missed appointments, resulting in additional care coordination and data exchange between inpatient and outpatient settings.

<u>What We Learned</u>

Each of the community mental health centers (CMHC) in the Workgroup were operating at different levels of integration and had different priorities for their programs' development. Heartland Health Centers (HHC) had distinct relationships with Trilogy, Turning Point, and Thresholds. The Workgroup's plan to share sensitive financial information, even among Workgroup members, challenged the customary resistance to exposing those kinds of details. Even in integrated programs, HHC and its CMHC partners still maintained separate budgets and different internal administrative processes. When the Workgroup began discussing what data collection was necessary, both the technical barriers to sharing data from different systems and the cultural barriers to going public with details of providers' business operations became clear. Working through these challenges and learning how integrated providers can continue to collaborate on deeper levels has been a necessary and helpful exercise in itself, as the Workgroup prepares for its next steps.

3. Data Exchange

<u>The Problem</u>

The inability to exchange health information electronically between primary care providers and behavioral health providers, and with hospitals, payers, State agencies, and community-based organizations, is a foundational barrier to integrating services. In the short-term, all providers need to identify work-arounds and interim solutions to meet the data exchange demands of Integrated Health Homes. However, Illinois will also require system-level policy reforms for longer-term, larger-scale strategies for information sharing that address the technical and financial barriers, practice change challenges, and privacy, confidentiality, and trust concerns related to health information exchange.

<u>What We Learned</u>

When we began to create workgroups and prepare feasibility study designs, we considered a data exchange 'experiment' that would attempt a small-scale platform to share information across settings. However, we quickly realized that a feasibility study to test and improve a practical intervention was not appropriate for our Learning Collaborative. For one thing, we could not, on our own, define what it meant for data exchange to be "working," because we did not know what the State would require of Integrated Health Homes, or indeed if their proposal would even be approved by the federal government. We also faced a general weakness of quality measurement in the area of behavioral health and even more so for behavioral health integration with primary care. Our primary care members in the Learning Collaborative were FQHCs, which are required to report only one behavioral health-related metric, screening for depression. Performance measures that define quality in process-of-care and recovery-oriented outcomes are missing, but those kinds of measures of evidence-based, person-centered care are what the Learning Collaborative needed to guide a data exchange strategy, given our other integration criteria.

Why a Behavioral Health Learning Collaborative?

Health & Medicine Policy Research Group (Health & Medicine) works to improve the health of all people in Illinois by promoting health equity. In pursuit of this mission, Health & Medicine seeks partners to identify urgent needs and work together to find solutions. In 2001, Health & Medicine launched the Center for Long-Term Care Reform to promote a just system of long-term services and supports that enables people to live according to their own goals and values. The Center focused its policy work on the over-use of institutionalization among older adults with chronic illness and functional impairment, and advocated for improvements to Illinois' home- and community-based services programs. At the same time the Center partnered with Rush University Medical Center to address one major cause of unnecessary institutionalization of older adults—poor post-discharge transitions from hospital to home—through the Bridge Model for transitional care.

The systemic weaknesses and institutional bias that the Center targeted in its work for older adults is strikingly similar to those found in the behavioral health system. Like older adults with chronic physical illness, people with mental illness and substance use disorders often require long-term supports in order to manage their conditions and live independently. People with behavioral health conditions are also frequently hospitalized, rehospitalized, and institutionalized when community-based services could prevent that disruptive and expensive utilization of facility-based care. While behavioral health symptoms drive some of this institutionalization, oftentimes the physical health issues of people with mental illness and substance use disorders go untreated until symptoms become an overwhelming crisis, resulting in the use of emergency rooms as primary care clinics. A project to improve community-based behavioral health *and* primary care services was therefore a natural extension of the Center's work.

A Health & Medicine initiative to address behavioral health outcomes also naturally included an equity dimension. As a population within the health care system, people with behavioral health conditions experience differences in access to care, quality of treatment, and outcomes that are avoidable, unfair, and unjust. Despite expansions in insurance coverage for people with behavioral health conditions, staying insured and accessing care remains an ongoing challenge.[1] Additionally, people with serious mental illness face significantly lower life expectancy, social and legal barriers to treatment, and greater risks for complex, and oftentimes, preventable health problems such as diabetes, heart disease, high blood pressure, and asthma. This may be in part due to behavioral health conditions leading to substantial impairment in carrying out major life activities.[2]

Within the population of people with behavioral health conditions, socio-economic inequities are also present, and the healthcare delivery system is poorly prepared to address the root causes of these inequities or their consequences.[3] The Healthy Chicago 2.0 2016 survey of Chicago residents found that treatment rates for people reporting serious psychological distress were highest for white Chicagoans and lowest for African

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[1] Health Insurance Coverage in the United States: 2016. US Census Bureau, 2017. https://www.census.gov/library/publications/2017/demo/p60-260.html

[2] Parks J, Svendsen D, Singer P, Foti M. Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20 and%20Mortaility%20-%20Final%2011-06.pdf

[3] Lee S, O'Neill A, Park J, et al. Health insurance moderates the association between immigrant length of stay and health status. J Immigrant Minority Health. April 2012; 14(2):345-349. doi:10.1007/s10903-010-9411-z

Americans.[4] Behavioral healthcare services that would create a safety net are in fact lacking,[5] and found to be less available to African Americans due to poverty.[6] Healthcare clinics are not equally available in all geographic areas and access is hindered by inadequate public transportation,[7] or may be found in high-crime areas.[8] Health & Medicine's Center for Long-Term Care Reform has released a separate Policy Brief on Behavioral Health Inequities In Illinois, available here, that explores these issues in more depth.

Integrated care—the coordination of mental health, substance use, and primary care services—presented itself as a potential solution to the overuse of institutional care, the inequities in behavioral health, and the overall quality of services and outcomes for people with behavioral health conditions in Illinois. According to the SAMSHA's strategic plan, "Leading Change 2.0: Advancing the Behavioral Health of the nation 2015-2018," integrated care has demonstrated the best outcomes and is the most effective approach to caring for people with complex healthcare needs.[9] A community-based participatory research study of African Americans who were homeless with mental illness also concluded that integrate behavioral and primary care services is urgently needed.

Responding to the need for equity-oriented integrated health care, Health & Medicine's Center for Long-Term Care Reform chose to launch the Behavioral Health-Primary Care Integration Learning Collaborative to guide a local advocacy agenda and facilitate practice-level changes to improve the lives of people

with mental illness and substance use disorder. The Behavioral Health-Primary Care Integration Learning Collaborative is an interdisciplinary group of community behavioral health agencies, primary care providers, facility-based behavioral health providers, people in recovery, and a managed care organization who have worked together to identify and adopt innovative strategies for behavioral health-primary care integration in Illinois. We choose a learning collaborative framework for the project based on our past experience and expertise in convening multiple stakeholders to tackle complex problems in healthcare. In particular, the

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[4] Healthy Chicago Survey, Chicago Department of Public Health, 2016. https://www.chicagohealthatlas.org/indicators/behavioral-health-treatment

[5] Darnell J. What is the role of free clinics in the safety net? Med Care. November 2011; 49(11):978-84. doi: 10.1097/MLR.0b013e3182358e6d.

[6] Lanouette NM, Folsom DP, Sciolla A, et al. Psychotropic medication nonadherence among United States Latinos: a comprehensive review of the literature. Psychiatric Serv. 2009; 60(2):157-174. doi:10.1176/appi.ps.60.2.157

[7] Bazzoli GJ, Woolton L, Hsieh HM, et al. The effects of safety net hospital closures and conversions on patient travel distance to hospital services. Health Services Research. February 2012; 47(1):129-150. doi: 10.1111/j.1475-6773.2011.01318.x

[8] Hanson RF, Self-Brown S. Screening and assessment of crime victimization and its effects. J Traumatic Stress. April 2010; 23(2):207-214. doi: 10.1002/jts.20503

[9] Leading Change 2.0: Advancing Behavioral Health of the Nation 2015-2018. Substance Abuse and Mental Health Services Administration, September 2014. https://store.samhsa.gov/product/PEP14-LEADCHANGE2

Center's partnership with the Bridge Model made clear that innovations in healthcare do not fix problems at a single point in time, but rather correct the course of day-to-day practice to avoid problems and improve outcomes. This requires diligent monitoring of processes, rapid bi-directional learning between research and practice, and the flexibility to use evidence for real time improvements.

These were our motivations for starting the Learning Collaborative, and we quickly found allies who saw the same potential in assembling a team to drive improvements in integrated care in Illinois. **This Playbook describes how we engaged stakeholders to refine our vision for the Learning Collaborative, recruited members who had the capacity to fully participate in a multi-year project, and established goals and processes to reach them. We also offer preliminary reports from the workgroups that the Learning Collaborative created to address major gaps in integrated care— hospital transitional care, financial sustainability, and data exchange.** These workgroups and their goals arose out of discussions of the criteria for 'integration' of behavioral health and primary care, the challenges to implementing those criteria, and the potential for practice-level solutions in the context of both budget crisis and political uncertainty.

Building a Team

Recruiting Members
Statewide Provider Organizations are Vital Partners

When Health & Medicine began planning a behavioral health project for the Center for Long-Term Care Reform, Medicaid managed care was in its early stages and managed care organizations (MCOs) were looking for ways to better coordinate care for their members while providers were attempting to forge more effective partnerships with MCOs. This coincided with the Blue Cross Blue Shield of Illinois Foundation announcing its interest in integrated care, and the Center's increased experience of the value of rapid learning cycles and continuous quality improvement through its partnership in the Bridge Model. Therefore, the Center began to explore the need for a learning collaborative to support integrated behavioral health and primary care.

A key lesson that emerged from those early days of planning for the Learning Collaborative was the enormous value of statewide membership organizations, in this case the Community Behavioral Health Association (CBHA). Leadership from CBHA possessed specific expertise in behavioral health and shared their advice on the opportunities and challenges to integrated care, but they are also consistently gauging the needs, plans, and concerns of their member organizations across the state. When CBHA leadership agreed that a learning collaborative could move integration forward and help providers and MCOs improve care for members with mental illness and substance use disorder, we were confident that we had found the right project for the Center.

CBHA's strength of having a 'finger on the pulse' of behavioral health providers also helped with recruiting the right team members for the Learning Collaborative. CBHA knew which of their members were on the leading edge of integrated care and, crucially, they also knew who had the capacity to invest time and staff resources to participate in regular Collaborative activities. Since integration with primary care was also a CBHA priority, they were also familiar with primary care providers who were prepared to partner with behavioral health agencies to expand access to care for individuals with complex medical and social needs. Together with Health & Medicine's decades-long relationships with area Federally Qualified Health Centers, provider organizations, advocates, and policy makers, CBHA's connection to Illinois' network of behavioral health providers proved invaluable to building a strong team to start and guide the Learning Collaborative.

Finally, while we suspected that a Learning Collaborative operated out of the Center would be more effective if it targeted the Chicago-area (where our offices are located and where we had the strongest relationships) it

was important not to be wholly indifferent to other areas of the state, including those that, at the time, were not part of Illinois mandatory managed care program. As a statewide membership organization, CBHA brought the perspective of downstate and rural populations to the Learning Collaborative's deliberations and initiatives.

Blue Cross Blue Shield Foundation's funding allowed the Center to offer each member organization a stipend to compensate them for the time they would spend on Learning Collaborative activities. Given the demands on staff time and the budget constraints of most providers, offsetting at least part of the cost of participation is a crucial element of any learning collaborative or quality improvement project.

Engage People with Lived Experience from the Very Beginning

The Center for Long-Term Care Reform has a history of community-based participatory research in the aging field and a commitment to the disability rights movement's "nothing about us without us" ethos. This orientation toward the consumer voice was a great advantage in setting up the Learning Collaborative because we had relationships with self-advocates to draw upon. Listening to people with lived experience cannot be an optional step in the planning stages of starting a learning collaborative or other quality improvement initiative, as the early decisions that organizers make will influence the entire course of the project.

It is true that integrated care requires partnerships, care coordination, and communication between diverse *providers*. Medical providers, behavioral health providers, and social service providers need to work together, share information, and implement care plans as a team. The lead role in integrated care, however, must be the person that team of providers serves, and that person brings along a web of relationships—family members, friends, as well as connections to communities based on geography, faith, or interests. Partnering with the person means putting them at the center of the integrated practice, building plans, processes, and teams around their goals, preferences, and needs.

We knew that the Learning Collaborative's lessons would be missing this crucial component if we did not take special care to recruit a strong, experienced self-advocate. We were fortunate that Illinois is home to several self-advocacy organizations, including Centers for Independent Living but also mental illness-specific organizations like Next Steps and the Depression and Bipolar Support Alliance, as well as provider-sponsored peer support and training programs such as Thresholds' Peer Success program. Staff from the Center had worked with these groups in the past, and consulted them immediately to receive their guidance on integrated care and operating a person-centered learning collaborative. We hope that that that influence is present throughout this Playbook and all of the work of the Collaborative.

Common Analysis of Problems and Solutions

Having recruited a group of providers, payers, and self-advocates who were involved in integrated care projects and interested in moving them forward through collaborative learning, we then had to find a common starting point for our work. The word 'integration' is loaded with various assumptions and implications that differ across a range of stakeholders. Discussing what we meant by 'integrated behavioral health and primary care' unearthed these differences, and even conflicts. Definitions of the problem integration is intended to solve, for example, often focus on the costs of fragmented care—10% of Medicaid recipients with behavioral health conditions account for 72% of behavioral health expenditures.[10] For a payer, the disproportionate expenditure, together with disappointing outcomes, represents a failure to deploy their financial resources for the best interests of their members. For a person with lived experience, however, this articulation of the

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[10] FY15 Illinois Department of Healthcare and Family Services claims data

purpose of integration may appear to make the person herself the problem, as the generator of unsustainable costs. Alternately, a residential service provider may consider the 24/7 access to an array of medical and behavioral health providers in their facilities as the epitome of integration, while a community-based mental health agency may regard independent community living, with access to coordinated outpatient services as well as to employment, education, and a meaningful social life, as a central goal of integration.

An especially difficult decision for the Behavioral-Health Learning Collaborative involved the scope of the Learning Collaborative—were we focusing our attention on non-elderly adults? Or were we including children and adolescents and older adults? Veterans? People with dual diagnosis of mental illness and developmental/intellectual disorders? Was this a Medicaid Learning Collaborative or were we addressing barriers to care for people who are uninsured? Naturally, no one wanted to exclude any population from the work, but narrowing the scope of a learning collaborative is a necessary step if practical lessons are to be produced. Several members made a strong case for targeting at-risk populations, including youth, for whom preventive behavioral health services, integrated with primary care, could avoid the eventual decline into a high-need group. After several discussions, members of the Behavioral Health-Primary Care Integration Learning Collaborative voted to focus on adults with moderate- to high-need behavioral health conditions, a population for which we believed we could have the most impact with our limited resources.

Having these discussions early is an important step in building the team. Even if not all disagreements can be resolved, they can be noted in the open and regarded respectfully in future conversations and decision-making. Frank conversations that did not shy away from disagreements during early in-person meetings helped build a sense of common purpose that encompassed many differing perspectives. There are several lessons for other learning collaboratives from our experience building this team:

- A subset of Learning Collaborative members composed the Planning Team, which met to set goals for each meeting and webinar. The Planning Team allowed Learning Collaborative members to influence planning and take leadership on projects without overtaxing participants.
- Remaining mindful of the value of members' time, the Learning Collaborative staff arranged for online surveys and 'working webinars' in which members refined decisions, goals, and next steps in real time on shared documents.
- After every meeting or webinar, Health & Medicine staff sent short evaluation surveys to ensure we were meeting the needs of the members. The survey gave staff another source of feedback, and gave members who may have been less comfortable speaking in meetings or using the webinar technology to communicate their suggestions and concerns.
- Members agreed on ground rules, including the commitment to assign two individuals from each member organization to attend all Collaborative events to ensure stability and continuity in our work.
- During in-person meetings, members participated in interactive exercises facilitated by an external consultant who brought expertise along with objectivity to encourage open, honest dialogue and active engagement with decision-making in the Learning Collaborative.

Defining Integration

Learning Collaborative members agreed that our goal was to identify actionable steps toward implementing effective strategies for integration of behavioral health and primary care. In order to achieve this goal, we needed to have a common understanding of what 'integration' fundamentally meant for the Learning Collaborative and a common vocabulary for *how* practices could structure service delivery to implement more effective integrated care.

We began by sharing a [Working Paper on Best Practices in Behavioral-Physical Health Integration](), written by MD/MPH intern Natasha Ahn. This paper presented the evidence for integrated care's impact on health outcomes, highlighting exemplar studies from SAMHSA and the University of Washington's AIMS Center and

describing a continuum of integration models from improvements in collaboration between separate providers to fully integrate systems of care. Ahn then questioned the replicability of such models, concluding that there is no "golden formula" for integration that fits every health care context and population served. Rather, Ahn distilled foundational principles that are present in successfully implemented programs and defined key areas of restructuring that allow organizational flexibility and adoption to local context: comprehensive services, patient focus, interprofessional teams, performance management, information systems, organizational leadership, physician integration, governance structures, and financial management. Ahn's paper became the starting point for our discussions about a common definition of behavioral health-primary care integration.

When we convened the Learning Collaborative after distributing the Working Paper, we found that providers rely on another framework for integration: the SAMHSA-HRSA Center for Integrated Health Solutions' Four Quadrants Model. The Four Quadrants categorize people by their behavioral health and physical health risks and complexity and match those needs with the level of collaboration needed.

This model was helpful for starting conversations about the different populations our provider-members tended to serve, and for deliberating over the focus of the Learning Collaborative: Where we working on prevention, to help lower-need individuals from becoming sicker? Or were we aiming to address the highest-need individuals, the people who had been failed by our fragmented system? Although it was useful in raising these questions, our discussions revealed that, for our purposes, the Four Quadrant Model did not adequately take into account the fluidity of individuals moving *between* quadrants as their physical, mental, or addiction status changes. With ongoing treatment utilization, intensive case management, and the natural progression of health and addiction, it is necessary to acknowledge the model's limitations of considering ones place in a single quadrant as "fixed."

Like Ahn, we concluded that a continuum of integration was a more useful framework for understanding what we were doing together in the Learning Collaborative. To organize the various models and strategies that have materialized, an expert panel at SAMHSA-HRSA, led by Heath and colleagues (2013) developed a conceptual framework of integrated care that defines six levels of collaboration spanning three practice structures. The six levels of collaboration range from minimal collaboration (patients are referred to a provider at another practice site and providers have minimal communication) to full collaboration in a merged, integrated practice for all patients (providers develop and implement collaborative treatment plans for all patients). The three practice structures, which progress towards a fully integrated system, include coordinated care, co-located care, and integrated care (Heath et al., 2013). Integration models can be placed along a continuum based on their practice structures and strategies used to enhance coordination and collaboration (Gerrity, 2016). The continuum represents a progression towards full integration, but strategies to enhance care coordination and collaboration may be used in combination or may fit in multiple levels (Gerrity, 2016).

The continuum provided the Learning Collaborative with a schema for understanding our baseline, our goals, and our progress. Integrated care remains an immensely complex topic and creating a common language and concepts that could be consistently understood and implemented by health systems, researchers, policymakers, providers, payers, and hopefully the patients themselves, was a normal developmental stage in this emerging field (Peek et al., 2011). A Learning Collaborative member directed us to the Agency for Healthcare Research and Quality's (AHRQ) Lexicon for Behavioral Health and Primary Care Integration which offered standardized definitions, practice parameters, and quality metrics to improve effective communication and concerted action of stakeholders in integrated care (Peek et al., 2013).

Based on discussions at in-person meetings and in 'working webinars' the Learning Collaborative refined our consensus definition of integrated behavioral health and primary care:

> **"Care that results from a practice team of primary care and behavioral health clinicians—who partner with community-based and wraparound service providers—which may include co-**

location and electronic health records (EHRs) sharing data, 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 physical health, mental health, and substance use disorder conditions, health behaviors (including their contribution to chronic medical illness), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Recognizing and Adapting to the Changing Policy Context for Integration

The Learning Collaborative was launched based on the belief that local action from providers, people with lived experience, and payers can make a meaningful impact on the quality, accessibility, and cost of services for people with behavioral health conditions. We also aimed to prove to others—health systems, insurers, and governments—that practice-transforming, life-changing reforms are possible and deserved support to drive them further and reach every person in need. In order to catalyze system transformation in this way, however, the Learning Collaborative needed to be aware of and nimbly responsive to the policy context for integrated care on the federal, state, and local level.

Federally, the Affordable Care Act (ACA) and the Centers for Medicare and Medicaid Services (CMS) provided several policy levers to promote person-centered care for individuals with behavioral health needs including health homes, the expansion of Medicaid eligibility, the inclusion of behavioral health services in essential benefits that insurers must cover, and funding of recovery supports such as supported employment or peer support (Davidson, 2016). Also under the ACA, Medicare Accountable Care Organizations and the Medicare-Medicaid Financial Alignment Initiative, and a movement towards more holistic and integrated care through different payment models such as value-based, pay for performance, and bundled payments, aimed to change the way health care is financed in the U.S. Beyond the ACA, the Excellence in Mental Health Act created Certified Community Behavioral Health Clinics (CCBHCs), authorizing a two-year demonstration program for eight states to pilot CCBHCs and track their progress in meeting specific criteria emphasizing high-quality, integrated care (SAMHSA, 2017)(National Council for Behavioral Health, 2017).

When the Learning Collaborative started in 2015, any policy questions involved these federal programs and the extent to which Illinois would participate in various pilots and demonstration programs. Indeed, the uncertainty regarding whether Illinois would apply to participate in SAMHSA's Certified Community Behavioral Health Clinics demonstration strongly influenced the decision-making of the Learning Collaborative. Although Illinois chose not to apply for the CCBHC pilot, advocates continue to pursue expansion of CCBHCs beyond the eight states chosen in 2016.

The example of the role of CCBHCs in the Learning Collaborative's decision-making demonstrates the importance of understanding and openly discussing the risks and opportunities presented by policy changes. The ambitious scope of CCBHCs—they are required to provide nine required types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, and care coordination—together with the uncertainty about whether Illinois would soon or ever implement this model created a dilemma for the Learning Collaborative. If we chose to adopt the CCBHC requirements as our own criterion for integrated care, then we were locking ourselves into a resource-intensive service model that may never take root in Illinois. If, on the other hand, we diverged from the CCBHC requirement and looked instead for opportunities to adapt the requirements to local circumstances, we risked becoming misaligned with standards that could become the norm in integrated care. In the end, as we discuss in the Six Criteria section of this Playbook, no member of the Learning Collaborative believed that the costs of meeting the CCBHC requirements, without the additional funding that came with the pilots, justified the potential benefit, and we steered a different course to identify core integrated care services that we had the capacity to impact.

With dimming hopes for CCBHCs in Illinois, the Rauner administration's proposal for Integrated Health Homes increasingly drew the Learning Collaborative's attention. Integrated Health Homes program, recently approved by CMS, will assign every Medicaid enrollee to a provider that would be responsible for coordinating all physical, behavioral, and social needs.[11] Adopting Integrated Health Homes as a framework for our own integration efforts, we looked for lessons from health home programs in other states. Our neighbors in Missouri had been operating a Health Home program since 2011 and shared enlightening experiences around the training needs of health home staff and leadership, workflow issues that interfered with EHR data transmission, and the difficult task of setting maximum caseloads for care managers. These lessons, shared in guest webinars and ongoing consultation with leadership from Missouri and Washington State's health home programs, guided the Learning Collaborative's planning for integration strategies as well as our policy advocacy to support necessary system-wide investments in technical support and data exchange for future integrated health homes in Illinois. More details on lessons from Missouri and Washington health homes is included in the Learning Collaborative's [Policy Lessons on Integration](#) brief.

While keeping a close eye on the progress of the IHH proposal, the Learning Collaborative's overwhelming state-level policy concern was, from the beginning, the growth of Medicaid managed care in Illinois. Integrating health care services was the charge of MCOs in Illinois since mandatory, capitated managed care was launched in 2011. Other states that had longer histories of managed care had begun to 'carve-in' behavioral health services that had previously been excluded from capitated programs. At least 16 states are now providing or planning to provide behavioral health services within an integrated health plan (CHCS, 2016). Making one entity accountable for physical and behavioral health services of a defined membership should help to identify and addresses a more complete array of health needs for those members. Additionally, this structure gives bottom-line incentives to expand access to primary, preventive, and community-based social services and prevent avoidable and costly hospitalizations and institutionalization (Hamblin, 2016). Decades of fragmented, uncoordinated systems of medical, behavioral health, and social services provision, however, create a powerful inertial resistance to integration. Medicaid providers that had found ways to survive and serve clients in the context of grant-based or fee-for-service payments suddenly needed to learn how to contract with MCOs. This demand on providers created significant friction in the form of new and unfamiliar operational challenges for certification and billing that led to higher administrative expenses and breakdowns in trust and communication between MCOs and providers. Identifying and implementing innovative payer-provider strategies to overcome those barriers was a major motivation for starting the Learning Collaborative and for partnering with Blue Cross Blue Shield of Illinois, which operates a managed care health plan in Illinois.

Managed care has also defined the shape of most other health reform initiatives in Illinois that affected the Learning Collaborative's work. Plans for Integrated Health Homes, expansion of telehealth and telepsychiatry, and an ambitious Behavioral Health Transformation 1115 Waiver all included MCOs as leading participants in the delivery, payment, and quality oversight of these reforms. Before 2018, the exclusion of large portions of the state, mostly rural areas, from managed care, added complexity to any analysis of the impact of these changes. In Chicago, for example, MCOs would surely take on key roles in setting up and operating Health Homes and certifying and reimbursing providers of tele-psychiatry. In southern Illinois, however, other organizations would have to fill the MCO role in implementing those programs. A managed care 're-boot' expanded managed care statewide in 2018, simplifying that kind of analysis but also bringing new challenges to rural providers and Medicaid members who will have to adapt to working with MCOs.

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[11] Medicaid Managed Care Request for Proposals, Illinois Department of Healthcare and Family Services, 2018. https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Documents/2018-24-001_RFP_Appendix_V.pdf
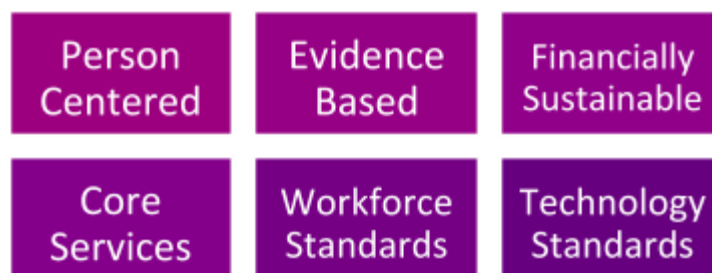
In other states and at other times, a learning collaborative with the same overall goal—improving integrated behavioral health and primary care—would be responding to different policy trends. Some states have far more mature managed care systems, for example, and would benefit more from learning and replicating proven interventions so that all insurers and providers implement best practices. Other states may be using managed fee-for-service approaches and the center of attention in policy-making could be a State agency or statewide Administrative Services Organization. Still other communities may see the most potential in improving how commercial insurers coordinate services for young people who are on their parent's health plan, to avoid the spiral of crisis, disability, and lifelong reliance on Medicaid.

For a learning collaborative starting in Illinois in 2015, improving on-the-ground implementation of managed care was a clear priority. Operating throughout 2016 and 2017 meant that Illinois' budget crisis was an enormous part of the policy background for the Learning Collaborative's work. Although we hope that lessons for surviving and continuing innovative reforms as the State itself struggled to function without a complete state budget for over two years will not be needed, it is a testament to the strength, resilience, and commitment of the Learning Collaborative's members that they continued their work amidst that unprecedented state fiscal crisis.

The Work for the Learning Collaborative: Defining Criteria, Identifying Gaps, Launching Feasibility Studies

After defining "integration" for the purposes of the Learning Collaborative, we began breaking it down into its component parts. Our goal was to create a consensus on the criteria without which a practice or a model could not be called "integrated" according to our definition. These criteria would then serve as the basis for identifying gaps in existing practices and in the Illinois health care system, focusing on the Medicaid program, and developing solutions to fill those gaps that we could test as a Learning Collaborative. Using the same techniques described above, we convened the team regularly to define and refine our integration criteria. We then identified practices that Learning Collaborative members were implementing that partly or entirely fulfilled each criterion, and built workgroups to address gaps that we felt we could target through a collaborative learning process.

The Six Criteria define the goal of integration that the Collaborative is pursuing. They are not a checklist to be marked as complete when a particular accomplishment is achieved, but instead an ongoing reminder of the principles that bring us together for this common purpose. Neither are the criteria discrete principles. They are instead flexible strategies that are interconnected with one other and, when conducted in harmony with one other, create the most optimal conditions. The initial Six Criteria represent the ongoing challenge to do better, and the Learning Collaborative is a venue to answer that challenge by listening to each other with openness, respect, and hope. The Six Criteria for an integrated behavioral health-primary care model are:

Person Centered	Evidence Based	Financially Sustainable
Core Services	Workforce Standards	Technology Standards

The following sections of the playbook are a collection of strategies, practices, and policies for other agencies to adopt and adapt to move along the continuum of integration. Each section identifies common challenges identified through the Learning Collaborative's practical expertise and that is supported in the literature. The playbook then describes the three workgroups that grew out of discussions of the major gaps in existing practice:

- **Hospital Transitional Care Workgroup** addressing a shortcoming in Core Services that interferes with community-based, person-centered recovery,
- **Financial Sustainability** addressing an overarching challenge to integration as well as the specific Financially Sustainable criterion, and
- **Data Exchange and Behavioral Health Quality Measures Workgroup** addressing gaps in Technology Standards criterion that hold back progress on each of the other criterion as well.

The Six Criteria

1. Person Centered

The Learning Collaborative agreed that any integrated model must be person-centered, and therefore must meaningfully incorporate the consumer voice; be physically, geographically, linguistically, and culturally accessible; and be trauma-informed. We considered ways to operationalize a standard definition of 'person-centered care,' and have used this framework to guide our ongoing work on integration.

> **Person-centered care, which is also known as patient-centered care, means consumers have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual.- [12]**
>
> Substance Abuse and Mental Health Services Administration (SAMHSA), Person- and family-centered care and support services. http://www.samhsa.gov/section-223/care-coordination/person-family-centered

Consumer Voice

To fulfill the promise of consumer control in SAMHSA's definition, practices must fully and meaningfully incorporate the voice of the consumers. Consumer participation in the integrated model should be formalized in written policy, which also describes the distinct role of family members and caregivers, with ongoing assessment that solicits input and response from the consumers. An example of a written policy is the Federally Qualified Healthcare Center (FQHC) model of consumer representation on the board.

If we are to meaningfully incorporate the voice of the consumer, first, we would need to do targeted outreach to find consumers who would be interested in participating in providers' advisory or governing boards. It is important to note that most people generally are not interested in being advocates—they just want to live their

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[12] In the Integrated Model Criteria Definitions, the term "consumer" means anyone who seeks or receives mental health or substance use treatment services or has formally sought or received services. The term "patient" stands in place of "consumer" in content areas that address clinical practice. We choose the word "consumer," given that this terminology is also commonly used in substance use treatment services. However, it is not the intent of this document to ignore the relevance and historical origin of the term "consumer" among individuals who have received, been subject to, or are seeking mental health or substance use services. We interchangeably refer to individuals with serious and persistent mental illness as "consumers" and "patients" throughout the document. We understand that these labels do not represent the identities of this diverse group of individuals.

lives, respectfully. Targeted outreach can be conducted to find people who are truly interested in being advocates for themselves and others and also interested in developing the knowledge and skills to become more effective in that role.

Person-centered and team-based care needs to be supported and incentivized by funding and infrastructure. There should be a dedicated funding stream to ensure that time for consumer input, education, and mentoring—which facilitates a true seat at the table—is done right. This type of best-practice takes time and money. To be truly accessible to consumers, who are a marginalized and highly stigmatized group of individuals, we would need to include stipends, transportation, and child care so that they can participate.[13]

Accessibility

Person-centered care means that accessibility of services and accommodations should be considered more broadly, but inclusive of physical and geographic accessibility (measured in the time and distance to integrated setting). Telehealth services can be considered, especially in geographically dispersed or rural areas as well as areas where professional shortages make on-site services challenging. Whether in-person or remote, services should be culturally and linguistically appropriate—considerate of reading proficiency levels and low health literacy—and psychologically and emotionally accessible for each individual patient. Accountability to providing these culturally appropriate services is essential and more discussion about the kinds of tools that could continuously monitor accountability should be considered on a case by case basis. Culturally appropriate services will vary depending on the communities that receive services and the provider type.

Trauma-informed

Person-centered care aims to overcome historically program-centered care by supporting and treating the *whole person*, which includes addressing social determinants of health, which directly impact their health and wellness. A whole person model means, "The coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."[14] With specific attention to the social determinants of health, integrating physical and behavioral health care should also be inclusive of individual's social needs (i.e., housing, food, transportation, financial support, etc.), psychosocial needs (i.e., social, emotional, informational), and further support people to remain in their own homes or communities as long as they wish.

Examining and treating the person in the context of their environment also implies that care should be trauma-informed. Trauma-Informed Care (TIC) is the adoption of principles and practices that promote a culture of safety, empowerment, and healing. Based on what we know about the prevalence and impact of trauma, it is necessary to ensure widespread adoption of trauma-informed care. Providing care in a trauma-informed manner promotes positive health outcomes.[15] Trauma-informed care, with a focus on resilience and strength, should take seriously the harm people have experienced in the physical healthcare and behavioral healthcare system and be responsive to that in the delivery of services.

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[13] Many examples presented in "A Seat at the Table: Consumer Engagement Strategies Essential to the Success of State Dual Eligible Demonstration Projects" are also relevant to including the consumer voice in integrated practices. See: http://www.communitycatalyst.org/doc-store/publications/a-seat-at-the-table-duals-consumer-engagement.pdf

14 Maxwell J, Tobey R, Barron C, et al. National Approaches to Whole-Person Care in the Safety Net. California Association of Public Hospitals & Health Systems and the California Health Care Safety Net Institute. March 2014. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14261&lid=3

[15] Trauma-Informed Care, Substance Abuse and Mental Health Services Administration, nd. http://www.integration.samhsa.gov/clinical-practice/trauma#trauma_informed_care

> **A trauma-informed approach is defined by SAMHSA as a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[2]**

2. Core Services[16]

A major goal of integration is to improve timely access to services so that poorly coordinated handoffs, confusing referrals, or long wait-times for appointments do not interfere with recovery. The Learning Collaborative discussed what core services *must* be available in integrated care. Early on, we considered using the Certified Community Behavioral Health Clinics (CCBHC) required services as a starting point and adapting those services based on the person-centered criteria outlined above. An advantage of CCHBCs is that they present a distinct service delivery model for trauma-informed recovery outside the traditional four walls of a conventional health care facilities.[17] However, many of the CCBHC services—assessing and managing risk among a population, ensuring the availability of 24/7 crisis stabilization services, utilizing peer support effectively and sustainably, providing and maintaining housing stability—are not simple, discrete service lines that can be quickly implemented or purchased. The enormous challenges to starting-up, testing, and sustainably operating many CCBHC services will not be overcome without system-level reform and significant financial and operational support for practice-level change. Based on discussions within the Learning Collaborative, we have revised the list of required services for CCHBCs to identify a practical, comprehensive list of Core Services that define the parameters of an integrated practice. They can be found in the Learning Collaborative's Behavioral Health-Primary Care Integration Model Criteria Brief.

Fortunately, our list of "Core Services" overlaps heavily with the goals of Illinois' recently approved Behavioral Health Transformation 1115 waiver. Expanding service arrays to include a full range of services from prevention to crisis stabilization, and including support services for housing employment, are major goals of the 1115 waiver. The Learning Collaborative's ongoing efforts to test the feasibility of operationalizing our integration criteria should help build a stronger foundation for some of the reforms envisioned in the waiver pilots.

> **Since we cannot integrate what is not there, an integrated practice must provide the core services—ranging from early identification and intervention to service planning to crisis services, either directly or through referrals, necessary to meet the needs of the people it serves.**

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[16] Note that the State of Illinois' 1115 Waiver Application referred to "core" services as opposed to "preventive" services. We have been using "core services" to refer to the fundamental services, both preventive and curative, without which a practice could not be described as truly "integrated."

[17] " What is a CCBHC?" National Council for Behavioral Health, 2018. http://www.thenationalcouncil.org/wp-content/uploads/2015/11/Fact-Sheet_what-is-a-ccbhc-FINAL.pdf

Prevention

Although, as mentioned above, the Learning Collaborative decided to focus its efforts on high-need adults in order to foster the most meaningful and largest local impact for those with the highest rates of morbidity and mortality, we recognized the importance of prevention in any list of core services. Core services provided in integrated care settings must consider preventative programs and policies that integrate with community resources such as school resources, social-emotional learning and other therapeutic programming, trauma-informed practices, local businesses, social services organizations, and healthcare clinics. The Learning Collaborative recognized the profound potential of more robust public health programs that assist in the education, prevention, and treatment of mental illnesses from infancy to adulthood. Research shows that identification in early childhood could help improve health outcomes and the course of mental illness. Such interventions could be integrated into the school system or pediatric offices.

> **Moving beyond the traditional 'four-walls' approach delivering core services will require novel methods to reach and engage individuals that are informed by community involvement and education.**

Hospital Transitions to Community Based Primary Care and Behavioral Health Services

Establishing a linkage to a primary care provider is an essential element of a care plan for people with serious mental illness and/or substance use disorder, which are commonly associated with other chronic physical conditions. Much of the high morbidity and mortality rates for this population are attributable to preventative conditions that primary care providers are trained at treating. A primary care provider ensures that preventative measures, such as diabetes or depression screening are conducted, monitors treatment and medication regimens prescribed by specialists, and promotes overall health and wellness through routine appointments. The Learning Collaborative identified the lack of relationship to a regular primary care provider, who can coordinate with behavioral health and social service providers and support an individual's recovery and chronic disease management, as a major, actionable gap in the core services available in existing practice.

Learning Collaborative members saw an opportunity to fill this gap in the Core Services criterion by improving the handoff of care between hospital inpatient units and community-based providers, in particular to connect people with behavioral health conditions to primary care after their discharge. Hospital stays and discharges are disruptive for individuals, families, and provider teams, and at this pivot point in a continuum of care a person can fall through the cracks or, with the right processes, appropriate resources, and effective communication—can be re-connected with an integrated safety net. A Hospital Transitions Workgroup assembled to make progress toward the following goals:

- Improved communication between the behavioral health provider on hospital units and MCOs for moderately at-risk behavioral health patients admitted to psychiatric in-patient unit
- Primary Care identification or assignment for inpatient hospital behavioral health patients
- Integration of primary care and behavioral health care through improved continuum of care, care coordination, and quality care post-discharge

An important element of integrating primary care into a Behavioral Health client's care plan is client choice, and we regard choice as a parameter for the Hospital Transitions Workgroup's feasibility study. Specifically, whether a client wants to return to a former Primary Care or Specialty Care practice, or whether they want to select one from their MCO network of Primary and Specialty care practices, client choice is paramount. In this way, a flexible and nimble approach is required to integrate primary and behavioral healthcare, bound and driven by client choice.

We discuss the results of the Hospital Transitions Workgroup's project later in the Playbook.

3. Evidence-Based

A major motivation for starting the Learning Collaborative was to translate research evidence into practice by finding creative methods to implement evidence-based interventions in diverse real-world contexts. Barriers to translating research from "bench-to-bedside" thwart dissemination and adoption of evidence-based practices. This is not a problem unique to integration. In fact, *translational research,* aimed at enhancing the adoption of best practices in the community,[18] has emerged as a separate body of research, distinct from clinical research. The Learning Collaborative was influenced by translational research in our linking of evidence-based practice with innovative implementation strategies.

> **Evidence-based practice combines clinical expertise, consumer values and preferences, and external research evidence to the planning and implementation of services.**

In integrated behavioral health and primary care, an evidence-base supports effective interventions for screening, assessment, diagnosis, treatment, and disease management, as well as specific therapeutic techniques, such as motivational interviewing and Cognitive Behavioral Therapy (CBT) for co-occurring disorders. Learning Collaborative members shared their experience and expertise with evidence-based practice for integrated care, and identified challenges to implementation, including shortages of staff needed for specific programs such as ACT and gaps in validated quality metrics for behavioral health processes and outcomes.

We noted in particular that evidence-based integrated practice are less well-documented for "reverse integration"—bringing primary care into behavioral health care settings—than for integrating behavioral health services into primary care. Reverse integration is crucial for the high-need population the Learning Collaborative chose to focus on, and we therefore agreed on the need to test and document the implementation of *evidence-informed practices* as a necessary first step to build an evidence-base for integrated practices that are not well-documented in the literature.

Examples of evidence-based practices identified by the Learning Collaborative include:

- Integrated Treatment for Co-Occurring Disorders Evidence-Based (EBP) KIT, link here

- Wellness evidence based protocols include manualized curricula for chronic disease management (smoking cessation, nutrition & exercise).

- Brief CBT embedded in primary care and self-management goals

- Improving Mood—promoting Access to Collaborative Treatment (IMPACT) model, evaluated and implemented by Advancing Integrated Mental Health Solutions Center (AIMS) University of Washington, Psychiatric & Behavioral Sciences, Division of Integrated Care and Public Health. Trilogy is currently using as evaluation framework.

- Assertive Community Treatment (ACT) is good model for teams because RNs are constantly interacting with PC and BH in the clinic. Trilogy and Thresholds currently use ACT.

- Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assistance Therapy (MAT) for screening and treatment of substance abuse and addiction

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[18] National Institutes of Health. Definitions under Subsection 1 (Research Objectives), Section I (Funding Opportunity Description), Part II (Full Text of Announcement), of RFA-RM-07-007: Institutional Clinical and Translational Science Award (U54) Mar2007. [Accessed November 13, 2009.]. http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-07-007.html. [Ref list]

This approach to evidence-based practice guided our Workgroups, which sought to determine if practices actually fit within the current operational environment or if they conflict with clinical operations or clash with patient values or preferences. Based on this goal, we chose the general framework of feasibility studies for the Workgroups' activities. Feasibility studies focus on the intervention process and allow for iterative, adaptive improvements during the study. A feasibility study may be the first stage in a research continuum that ends in a randomized control trial, or it may serve as a developmental learning process that shapes future research and practice. Our Hospital Transitional Care and Financial Sustainability Workgroups developed plans based on the feasibility study framework, and a summary of their progress is in the next section.

In addition to our own collaborative learning activities, we knew that we would also want to leverage existing integration research, such as the Primary and Behavioral Health Care Integration (PBHCI) SAMHSA/HRSA integration grantee evaluation reports. However, practically speaking, most behavioral health services are not a single, standardized set of operations, but a flexible array of services curated to meet the needs of the diverse communities they serve. Thus, we agreed that implementing evidence-based practices should mimic this adaptability of local providers and be responsive to changing circumstances as well as to research, underscoring the importance of continuously monitoring and evaluating those practices to ensure that all communities receive the most effective services possible.

4. Financially Sustainable

Even a model with a strong evidence-base and flexibility to meet changing needs of providers, payers, and consumers will not achieve long-term success if it is not financially sustainable. Delivering cost-effective services is a challenge for the entire healthcare sector, and providing behavioral health and primary care services in an integrated setting is resource intensive. Adults with serious mental illness, who may have experienced trauma, require more time with health care professionals to develop trust, rapport, and discuss the treatment of their complex health and social needs. In addition, care coordination and case consultation between providers and payers, along with intensive case management, involves additional administrative and clinical expenses. Although the total cost of care is likely to be lower when care is coordinated to avoid service duplication and crisis hospitalizations, those savings are not always captured by the same organizations that invest in integrating care.

Facing this difficult landscape for financially sustainable integrated care, the Learning Collaborative was fortunate to have two members who had participated in an innovative partnership created by a Primary Care and Behavioral Health Integration (PBHCI) SAMHSA demonstration grant: Federally Qualified Health Center (FQHC) Heartland Health Centers and Community Mental Health Center (CMHC) Trilogy Behavioral Healthcare's full integration goes beyond co-location of services and is moving towards financial sustainability. A Learning Collaborative Workgroup on financial sustainability is taking this opportunity to derive lessons for forming financially viable partnerships between FQHCs and CMHCs. For example, FQHCs can bill for services like immunizations and group visits that CMHCs cannot bill for, while CHMCs may have grants for case management and evidence-based behavioral health treatment services that may not be available to FQHC patients. "Braiding" those reimbursement streams together at co-located clinics allows the partners to create an an array of services that would not be available from any one source. However, each organization must still track and account for revenue and expenses for each source separately. As the Workgroup report below describes, those distinctions make collecting, consolidating, and assessing data on costs, income streams, staffing, and outcomes very difficult. These consolidated data are necessary both to establish the value of the Heartland-Trilogy integrated model and to disseminate replicable strategies for other FQHC-CMHC partnerships.

Other integrated care models, such as Minnesota's Hennepin Health Program use braided funding to provide medical, behavioral health, and social services through a coordinated team. In the long-term, we expect to see

more blended financing models, shifting from pieced-together grants, fee-for-service payments, and per-member-per-month fees to more integrated, value-based payment methodologies that incentivize high-quality, cost-effective services. In order for value-based payment to work—to produce greater value for healthcare consumers—providers will need technical assistance to understand the operational, administrative, and organizational components of financially sustainable, high-quality integrated care.

> **Due to the fragmented nature of our reimbursement and billing practices for physical health, mental health, and substance use, advocacy is critical.**

The Learning Collaborative's Financial Sustainability Workgroup is investing time and energy to contribute lessons that can be a starting point for practice-level and system-level change. However, we recognized from the beginning that practice- or partnership-level change would not be enough. Due to the fragmented nature of our reimbursement and billing practices for physical health, mental health, and substance use, advocacy is critical. While Heartland-Trilogy and other members of the Learning Collaborative shared lessons on their own approaches to financial sustainability, most were also advocating for system level reforms. The Community Behavioral Healthcare Association helped pass a rate add-on that filled a dangerous gap in funding for psychiatrists in the midst of a major State budget crisis, and all members participated in some way in the stakeholder engagement process for the Illinois 1115 Waiver and State Health Homes proposal. Learning Collaborative members and the larger community of health advocates continue to seek reforms, including funding for prevention to augment the largely crisis-oriented 1115 waiver and expand access to community-based care as an alternative to incarceration. These reforms will be a necessary foundation on which to build a truly sustainable system of integrated care.

5. Workforce Standards

An integrated model with a sound financial plan needs to be implemented by people—the workforce that will actually provide and manage services. Person-centered care involves personalized or individual care and support delivered by a team of providers that are guided in their decision and approach by the person receiving services. In team-based care, or care teams, patients are engaged with multiple providers who ensure care continuity for the patient. Care teams are accountable for a distinct group of patients (not just the patients who happen to arrive seeking services), and are sensitive to patient and family preference.[19] In addition, the planning and implementation of service or care plans should be inclusive of and responsive to the individuals' goals, values, preferences, and motivations.

On the continuum of integration there are a variety of models that add a behavioral health professional to a primary care team or embed a primary care nurse into a behavioral health center. However, as integrated practice moves along the continuum, behavioral health and primary care team members become not only additive but transformative. Each team member begins to see their work as providing integrated care to the whole person, rather than being on the behavioral health or physical health 'side' of a team. This is a challenging demand for a workforce that has been trained in the context of rigid silos between behavioral and physical health. One of the key lessons that Health Homes programs from Missouri and Washington State shared with the Learning Collaborative was the need for early and ongoing training for existing staff to understand how to work together, which often required stretching well outside their comfort zones. Nurses who had committed their careers to treating and managing physical illness and injury were asked to shift that

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[19] "Enpanelment." Safety Net Medical Home Initiative, nd. http://www.safetynetmedicalhome.org/change-concepts/empanelment

perspective to include screening, treatment, and referrals for mental illness and substance use disorders; social workers and psychologists who specialized in behavioral health interventions and counseling were expected to develop competencies in chronic disease management. Practice managers had to coordinate those teams and manage new per-member-per-month payments to optimize quality, patient experience, cost, and team members' job satisfaction. Every member of the Health Home teams needed support and training to successfully launch Health Homes in Missouri and Washington State, and core competencies and intensive training and technical assistance are a defining feature of the workforce standards for the Learning Collaborative.

This level of staff orientation, training, and technical assistance takes time and generates significant costs that may not be covered by future revenue generation of the integrated practice. Distinguishing between start-up costs that are unlikely to be recouped and ongoing operational expenses that should be recovered when the integrated practice is running at optimal levels is an issue the Financial Sustainability Workgroup has been addressing. One key question they are considering is whether only high-volume sites that can achieve the operational efficiency and economies of scale that are impossible for smaller practices can maintain integrated services. Shortages of behavioral health professionals makes this question more urgent. Illinois ranks 30th in the nation in mental health workforce availability, and shortages are much more acute in rural areas, where a behavioral health vacancy can take up to 18 months to fill.

The Health Homes program in Missouri discovered that their care manager-to-client caseload maximums were far too high, overburdening their staff. Learning from this experience in a neighboring state, Illinois providers and policymakers must design integrated practices, including Health Homes, with the capacity of the workforce in mind—building on models that have succeeded in Illinois, supporting practices to start-up and reach sustainability, and investing in the workforce for future expansion of integrated care. The Learning Collaborative's members successfully implemented strategies to integrate services in the extremely challenging environment of the Illinois budget crisis, and the Financial Sustainability Workgroup is currently developing concrete lessons for starting-up and operating financially sustainable integrated practices. At annual policy forums for the last three years, we have brought Learning Collaborative members and State agency leaders working on Behavioral Health Transformation together to learn from one another, a process we hope to continue as the State implements its 1115 waiver and Integrated Health Homes program.

Having an adequate supply of professional staff with the proper training to work on integrated teams is crucial and very challenging in the current environment. However, the Learning Collaborative also placed a priority on another workforce need—cultural competency and diversity in a workforce that will be engaging with and serving people from many different backgrounds. Peer support workers, for example, can act as trusted and motivating role models assisting others with behavioral health issues to manage health behaviors, navigate health care systems, identify community resources, develop recovery plans, and build skills in daily living (DBSA, 2016). Research has shown that peer support services can reduce recurrent psychiatric hospitalizations, improve individuals' relationships with their healthcare providers, and improve individuals' abilities to manage their symptoms. (Sledge, W., Lawless, M. & Sells, D., 2011). Building on Illinois' Certified Recovery Support Specialist workforce, peer support can maintain person-centeredness of integrated practice while supporting traditional behavioral health and primary care staff.

The 1115 waiver and Integrated Health Homes will bring mandates for team composition but also potential flexibility to pay for new kinds of staff to work together in new ways. To the extent that we know what works and what does not in team-based care, and specifically for distinct populations like people experiencing chronic homelessness or people with SMI or SUDs, Integrated Health Homes and payment reform may remove barriers to implementing effective team-based, integrated care.

6. Technology Standards

The Learning Collaborative recognized that Health Information Technology (HIT) and data exchange were key components of integrated care. The Six Criteria identified the components that a model must include to be meaningfully 'integrated.' Technology and data exchange became a criterion for integration because much of the work of connecting the existing behavioral health and physical health silos depends on sharing information and improving communication between providers. But data exchange also arose as a central challenge to fulfilling each of the other five criteria as well. (We describe the challenges and policy implications of data exchange for each criterion in a separate policy brief.)

Health care is still in the early stages of the kinds of deep technical transformation that other sectors have experienced. Privacy and confidentiality concerns certainly play a role in the slow pace of change, especially when stigmatized conditions like mental illness and substance use disorders are present. However, health care has always been a data-intensive sector, even if most information has been recorded, stored, and shared on paper. The fragmentation of providers creates a tangle of incompatible legacy information systems, some relying mostly on fax machines and paper records and others using various electronic record systems that can only rarely communicate with one another.

Health care silos are not only physical and technological—different providers in different locations using different information systems—but also operational and cultural. Hospitals, private physicians' practices, FQHCs, CMHCs, and managed care organizations all have very different perspectives on the use and goals of HIT. Most are operating under different demands for 'quality' performance and cost effectiveness, with MCOs and providers navigating a rapidly changing world of metrics and incentives from Medicaid, Medicare, and commercial insurers as well as quality rating agencies. Few of the wide array of metrics and incentives addressed behavioral health, however, and Learning Collaborative members recognized that without validated metrics of quality outcomes specifically for *integrated* care, conversations about data collection and information exchange lacked clarity of purpose. Moveover, organizations cannot make informed, strategic decisions about investment in HIT infrastructure and workforce without a better understanding of the outcomes they will be held accountable to.

History and organizational culture also influence approaches to data exchange, as we found when the question of confidentiality and privacy arose in Learning Collaborative discussions. Members whose experience was mostly in primary care settings were eager to share as much information as possible in order to truly serve the whole person and avoid dangerous errors due to lack of key information on medications and diagnoses. One member questioned the accommodation and even affirmation of stigma implied by specifically withholding information related to mental health and substance use disorder without complex consent processes. Learning Collaborative members from behavioral health providers were more likely to see data-sharing as a risk to the difficult process of building trusting relationships with people seeking behavioral health services. Reconciling these competing philosophical and practical approaches to data exchange is a necessary step for cooperation between behavioral health and primary care providers in integrated practices.

Although we have concluded that more investment in statewide infrastructure along with national standards for quality outcomes of integrated care are necessary, the learning collaborative framework is an excellent tool to explore incremental solutions that can begin to overcome the different perspectives on data sharing. Individual 'workarounds' to the enormous barriers to data exchange are too expensive and inconsistent to meet system-wide needs, but documenting mechanisms that Learning Collaborative members are using and sharing lessons learned can avoid the repetition of trial-and-error approaches and guide policy for larger-scale information exchange systems. Learning Collaborative members are experimenting with "integration engines" to link multiple non-standardized EHRs, participating in regional or local health information exchanges, or attempting to connect medical records with data on social determinants such as housing stability. Within our workgroups on Hospital Transitions and Financial Sustainability, the Learning Collaborative is identifying

areas where data systems can contribute to care coordination and improved outcomes for people with behavioral health conditions.

A Data Exchange and Behavioral Health Outcomes Workgroup has been conducting research, including provider surveys, to support the work of the Hospital Transitions and Financial Sustainability Workgroups and to develop advocacy positions for the Learning Collaborative. Their work and plans for the future are summarized in the next section.

Learning Collaborative Workgroups

Feasibility Studies

The Learning Collaborative identified two key operational challenges for integrated care: coordinating transitions back to the community following a psychiatric hospitalization, and maintaining a financially sustainable model that integrates primary care and behavioral health services. Keeping true to our commitment to pursue actionable research that can be translated into real-world results, we chose to conduct feasibility studies. A feasibility study, distinct from a pilot study, is an iterative, adaptive research method that focuses on the *process*. The study designs of the Learning Collaborative's Hospital Transitions and Financial Sustainability Workgroups are essentially designed to answer the question, "Can it work?" We expect that the answers will become practical lessons that can help others fill operational gaps in their own integrated practice.

Policy research

The Learning Collaborative also recognized that barriers to data exchange are a major challenge to integrating primary care and behavioral health. Our Data Exchange Workgroup is taking on questions of interoperability, privacy, and confidentiality, and the end goals of data exchange by examining our members' own experience, consulting with outside experts, and engaging with policy makers.

This section describes the work of the Learning Collaborative Workgroups and preliminary results of each project.

1. Hospital Transitional Care Workgroup

As discussed under the Core Services criterion above, the Learning Collaborative recognized the disruption of a hospitalization as a key pivot point in integrated care, and an area in urgent need of process improvement. Several Learning Collaborative members were involved with hospital-community partnerships that had improved transitions from ERs though co-location of crisis stabilization services and coordination of behavioral health after hospital discharge. Connecting people to *primary care* after a hospital discharge, however, was a serious challenge and one that clearly interferes with the goal of integrated care.

Given the urgency of the need, together with the expertise present in the Learning Collaborative, hospital transitional care was an ideal area to focus our attention. A workgroup convened and made a plan to explore the handoff between hospitals and primary care providers. The workgroup had many discussions about what sites could participate in a hospital transitional care study, what data could be collected and analyzed on a relatively short timeline, and what were realistic target populations and overall goals for the study. At the time of this Playbook's publication the workgroup was on the cusp of launching a project to strengthen and simplify the transitions of care process for BCBS Medicaid members at Sinai Health Systems and LSSI's hospital partner, Swedish Covenant Hospital.

Both Sinai and LSSI-Swedish Covenant have invested significant time and resources into improving care coordination for people presenting in their Emergency Department in behavioral health crisis. LSSI's Project IMPACT embeds a behavioral health crisis assessment team in Swedish Covenant Hospital's ED and LSSI's Welcoming Center provides a safe alternative to EDs as well as a bridge to long-term care for people with behavioral health conditions. Shortly after the launch of the Learning Collaborative, Sinai Health System opened Chicago's first ever behavioral health crisis stabilization unit (CSU) at Holy Cross Hospital, providing an alternative to standard EDs that ensures rapid access to psychiatric and behavioral health services. The CSU helps individuals in crisis return to their daily lives with minimal disruption and coordinates with Sinai's outpatient mental health clinics and expanded telepsychiatry program to ensure access to services in the community.

Building on this past work, Sinai and LSSI volunteered to serve as the participating sites for the Hospital Transitional Care Workgroup's feasibility study. Because Sinai and LSSI were both operating innovative programs to connect hospital patients to community-based behavioral health services, the Workgroup agreed that the most urgent need was to improve post-hospital linkage to primary care. If the study successfully identifies best practices in coordinating primary care follow-up following hospital discharge, then they can be incorporated into Sinai and Swedish Covenant Hospital and LSSI's existing processes for behavioral health follow-up, resulting in a powerful advance in behavioral health integration.

As is to be expected in a topic as complex as integrated transitional care, there were many more difficult decisions for the Workgroup to make. LSSI, Sinai, and BCBS, as the participating organizations in the study, led the planning with feedback from other Workgroup members and from the whole Collaborative at our regular meetings and webinars. Based on these discussions, the Workgroup agreed that the study would target BCBS Medicaid members with behavioral health conditions who are admitted to inpatient hospital units and have had one to three hospitalizations in the prior six months. These criteria exclude some important groups—people who are dually eligible for Medicare and Medicaid, people who visit the ED but are not admitted to an inpatient unit, higher-risk individuals with more frequent hospitalizations, and lower-risk individuals who could be deflected from future crisis through preventive interventions. These are all populations for whom similar collaborative learning projects could produce important lessons. We chose the target population that we felt we had the most ability to impact in a short period of time.

Importantly, the Workgroup was neither looking for temporary workarounds to transitional care challenges nor for a strict evaluation of a specific intervention. Rather, we want to examine transitional care processes— what happens on the unit, after discharge, and at follow-up appointments—and track specific metrics that guide real-time adjustments of those processes and, in the end, find best practices that can be disseminated and replicated. Best practices from the study would address communication between hospital and MCO care coordination staff to identify the patient's assessed risk and primary care providers relationship, communication of transition records between hospitals and primary care, and the actual follow-up with a post-discharge PCP appointment.

Two of those areas of focus—sharing the transition record and successful PCP follow-up after a hospitalization—can be tracked through specific Healthcare Effectiveness Data and Information Set (HEDIS) quality measures. The workgroup will have access to these validated measures through BCBS's administrative data to assess the efficacy of their processes. The success of those processes likely depends on hospital discharge planners knowing who the patient's primary care provider is and on patient engagement on the inpatient unit in order to plan for primary care follow-up after discharge. The workgroup expects to identify best practices for both processes: communicating primary care status at admission and motivating the patient to talk about their primary care relationship and a shared plan for post-discharge follow-up.

The workgroup will be launching the study in the summer of 2018. BCBS will identify 10-15 people who are admitted to Sinai or Swedish Covenant with a behavioral health diagnosis after an 'anchor date' and meet the

'moderate risk' criteria. BCBS will analyze de-identified HEDIS data for the six months prior to admission and for the six months following discharge. Hospital staff will communicate with BCBS to identify each patient's PCP, and if no PCP is on record with BCBS, Heartland Health Centers has offered to accept appointments for these patients. Whether a patient has a PCP on record or not, hospital-based care coordinators, along with their community partners, will need to find ways to motivate people to go to the post-discharge appointment.

The overall goal of the Workgroup is to change the trajectory for high utilizers by improving engagement and linkages to primary care after discharge. At the same time, BCBS, will examine the data from the study to identify other trends that can lead to further improvements. In general, discharge planning and care transitions processes will continue as usual in each study hospital. The close attention to those processes and their impact on specific HEDIS measures for 7- and 14-day primary care follow-up will reveal opportunities for process improvement and best practices that can be replicated in other hospitals. The study may also show policy-level gaps in, for example, funding for the care coordination resources necessary for efficacious transitional care and data collection and exchange between hospitals, primary care, behavioral health providers, and MCOs.

2. Financial Sustainability

Financial sustainability may seem like an obvious criterion for any health reform—if we want a reform to be widely adopted, it cannot bankrupt the organizations implementing it. The Learning Collaborative's Financial Sustainability Workgroup originally aimed to identify replicable mechanisms to viably finance the start-up and ongoing operations of integrated practices. In addition to the commitment of organization leaders to work together, one lesson we learned from the Workgroup is financial sustainability also represents an additional demand on partnering organizations to disclose more proprietary information, share more operational decision-making, and even consolidate portions of their budgets. This work can be difficult to sustain without leadership participation.

Administrative alignment is key to moving from physical co-location to higher-levels of integration, but there is no one model for building and growing these partnerships. Local relationships that tailor integration strategies to specific characteristics of provider type, reimbursement policies, patient volume and risk-level, and workforce capacity define financial as well as clinical decisions. The Financial Sustainability Workgroup brought together three Chicago-area CMHCs—Trilogy, Turning Point, and Thresholds—and the primary care partner they had in common, Heartland Health Centers (HHC), to better understand the true cost of integration and identify ways that FQHC-CMHC partnerships can sustainably cover those costs.

Each of the CMHCs in the Workgroup were operating at different levels of integration and had different priorities for their programs' development. Heartland Health Centers had distinct relationships with Trilogy, Turning Point, and Thresholds. The Workgroup's plan to share sensitive financial information, even among Workgroup members, challenged the customary resistance to exposing those kinds of details. Even in integrated programs, HHC and its CMHC partners still must maintain separate budgets due to separate funding streams (FQHC vs. IL HFS). When the Workgroup began discussing what data collection was necessary, both the technical barriers to sharing data from different systems and the cultural barriers to going public with details of providers' business operations became clear. Working through these challenges and learning how integrated providers can continue to collaborate on deeper levels has been a necessary and helpful exercise in itself as the Workgroup prepares for its next steps.

Trilogy Behavioral Health and Thresholds have taken the lead on data collection in the Workgroup, given that the Turning Point BH-PC integration program is only in the planning stages. One finding from all three organizations is that start-up funding is difficult to find. Trilogy and Thresholds worked with HHC to produce

a 'dry run' of data on each of their organization's shared client population characteristics, physician panel size, staffing types and ratios, service provision, operating costs, and income sources. Much of that data still requires significant cleaning before any analysis will produce conclusions about replicable mechanisms to achieve financial sustainability. They do agree that once beyond start-up, with enough patient volume, programs become more sustainable, but the complexity of analyzing the costs and benefits requires significant time and expertise to sort out specifics. The groups would like to continue if additional expertise and funding support for the feasibility study is acquired by the Learning Collaborative.

3. Data Exchange and Behavioral Health Outcomes

During the first year of the Learning Collaborative, after we had defined the Six Criteria, the members spent time 'mapping' their own integration practices to the Criteria, looking for both replicable successes and for gaps. We then sought out outside experts to offer additional ideas for fulfilling our criteria, especially for Technology Standards, an area where Learning Collaborative members felt less confidence about their own capacity to achieve the objective of seamless data exchange. The Health Home programs in Missouri and Washington State had experience with data exchange between primary care and behavioral health, but they were relying on pre-existing infrastructure that is lacking in Illinois. A HIT consultant who works with CBHA members also presented some low-tech, quickly implementable solutions for behavioral health-primary care integration.

When we began to create workgroups and prepare feasibility study designs, we considered a data exchange 'experiment' that would attempt a small-scale platform to share information across settings. However, we quickly realized that a feasibility study to test and improve a practical intervention was not appropriate for our Learning Collaborative. For one thing, we could not, on our own, define what it meant for data exchange to be "working," because we did not know what the State would require of Integrated Health Homes, or indeed if their proposal would even be approved by the federal government. We also faced a general weakness of quality measurement in the area of behavioral health and even more so for behavioral health integration with primary care. Our primary care members in the Learning Collaborative were FQHCs, which are required to report only one behavioral health-related metric, screening for depression. Performance measures that define quality in process-of-care and recovery-oriented outcomes are missing, but those kinds of measures of evidence-based, person-centered care are what the Learning Collaborative needed to guide a data exchange strategy, given our other integration criteria.

For these reasons, the Learning Collaborative decided that the time and resources required to launch a feasibility study would be better spent on continued research and support for the Hospital Transitions and Financial Sustainability Workgroups, both of which face daunting technological and data-sharing challenges. For example, although HEDIS behavioral health quality measures, to which MCOs are held accountable, included a new metric for follow-up after ED visits, hospitals in Illinois did not have a reliable, timely method to inform MCOs when a member arrived at the ED. While we did not expect to develop a comprehensive solution to that daunting problem, we do hope to find applicable lessons from the Hospital Transitions Workgroup's study. That study is especially concerned with improvements to communication between MCOs and hospital discharge planners so that the primary care status and assessed levels of care of admitted patients with behavioral health conditions are quickly shared with hospitals. This improvement in process should lead to better outcomes when people who are discharged after an inpatient admission are connected to the right services in the right setting to avoid recurring crisis and readmission. Such improvements should also create a foundation to build better communication between MCOs and hospital Emergency Departments to help fulfill the new HEDIS measure for post-ED follow-up.

More seamless, coordinated hospital transitions will more quickly and comfortably connect people with behavioral health conditions to community-based services for integrated primary care and behavioral health

services. These community-based providers also need additional resources to improve data collection and exchange. Community-based integrated care for the whole person depends on both integrated data across settings and financially sustainable practices rely on accurate data to monitor operations for cost-effectiveness, patient satisfaction, and quality outcomes. To begin to answer the question, 'how do we measure whether data is shared successfully?', the Data Exchange Workgroup surveyed Learning Collaborative members, using a tool developed by CBHA, to determine what EHR systems behavioral health and primary care providers are currently using and whether and how they are sharing data across those platforms. Internally, the survey helped hone the Learning Collaborative's focus on the current state of data exchange, the goals of improvements, and the barriers to implementation. The survey responses also confirmed a lesson from earlier discussions of data and technology—that behavioral health and primary care providers use health information technology in very different clinical contexts and do not share a common lexicon to discuss process improvement for mutual goals. The Learning Collaborative provided the time and also promoted conversations to begin to bridge this gap. However, health information technology and data exchange are specialized areas of integrated care, and a crucial next step will be to recruit IT staff from diverse providers to participate in similar collaborative learning and quality improvement projects.

Conclusion

In the course of working together as a Learning Collaborative, we encountered differences in approaches to integration and reservations about sharing sensitive information. However, the process of coming together to learn from one another drew individuals out of their "sphere of influence," as one member put it, to recognize the common challenges we face and to be reminded that there is strength in collaboration. What may seem like small, bureaucratic details—like establishing more consistent cost center allocation to track an integrated clinic's revenue and expenses—can actually be crucial pivot points for an emerging integrated care program.

Bringing people together and giving them the space to identify the most important problems they face and to deliberate over potential solutions is an ideal method to drive ground-up reforms that can guide system-level policy. Developing consensus criteria for the Learning Collaborative's long-term goal created a common vision and provided parameters to maintain focus on our core purpose and values. Health & Medicine staff regularly collected feedback from members on the value of the Learning Collaborative's activities.

As we moved forward with the workgroups and feasibility studies, one clear lesson was that the kind of collaborative research and quality improvement that we were led to pursue requires significant financial resources, staff time, and specialized expertise. The Learning Collaborative built a strong enough team to begin this work by generating a level of trust among different providers and a willingness to contribute time and energy to the early stages of the studies. Along with Health & Medicine's long-standing relationships with health care providers and advocates, the Learning Collaborative has leveraged scarce resources in difficult times, and members have continually voiced the importance of coming together to engage in collaborative learning and quality improvement. Health & Medicine's Behavioral Health-Primary Care Integration Learning Collaborative will continue and expand its role and build on the group's experience and knowledge to foster behavioral health integration, while seeking new partners and resources to amplify our impact throughout the state of Illinois and beyond.

As Illinois and other states embark on bold reforms to Medicaid and behavioral health services, we believe that learning collaboratives will have a role to play in implementing new policies, learning what facilitates and what interferes with reform, and adjusting policies and practices to respond to lessons from the field.