Behavioral Health-Primary Care Integration Model Criteria Brief

Definition of Behavioral Health and Primary Care Integration used by the Learning Collaborative: 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 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.   (adapted from 2013, Peek & National Integration Academy Council)
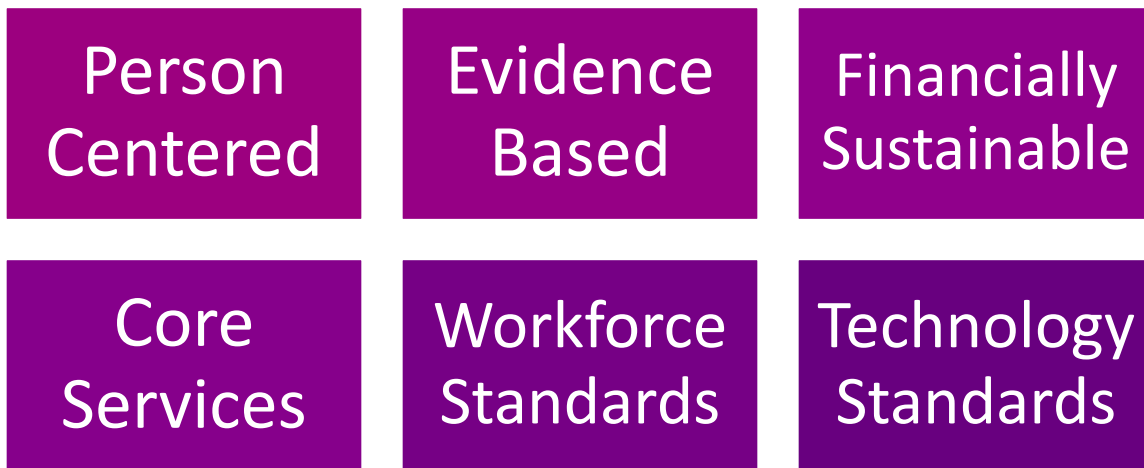
The Six Criteria

Health & Medicine Policy Research Group's Behavioral Health-Primary Care Integration Learning Collaborative began by carefully defining "integration" and breaking it down into its component parts. By doing this, the Collaborative created a common understanding of "integration" and surfaced flexible yet actionable steps towards achieving it.

Once the Learning Collaborative defined the six criteria that made a model "integrated," we then identified practices that Learning Collaborative members were implementing that partly or entirely fulfilled each criterion. Rather than defining a strict set of practices that may only work in specific conditions, we focused on the technical assistance needed to operationalize the basic principles of integration. Implied in this approach is that there are many models that fulfill the criteria for integration, and that weak points in a model can be strengthened by borrowing practices from others and carefully incorporating them into the existing framework of service delivery.

Although overarching system- reform will inevitably place high demands on individual actors in the system—the provider organizations, their staff, people with lived experience and their families, managed care organizations—a great deal of leadership will come from those individuals. The six consensus criteria, which have been the subject of continuous discussion and revision, provide the Learning Collaborative with a framework for testing new ideas and interrogating some old ideas. Each of these criteria is necessary and inter-related, and progress cannot be made on one without considering the demands of the other five.

The future work of the Learning Collaborative is to test practical strategies for adding effective interventions to existing integrated models, more completely fulfilling the six integration criteria.

The Six Criteria for an integrated behavioral health-primary care model:

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

Person-centered

"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."
--Substance Abuse and Mental Health Services Administration (SAMHSA).
https://www.samhsa.gov/section-223/care-coordination/person-family-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.

Consumer Voice

Consumer participation in an 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.

Targeted outreach and training should be conducted to find people who are truly interested in being advocates for themselves and others, and developing their knowledge and skills to become more effective in that role. For such training to be accessible to consumers who have often been marginalized and highly stigmatized, arrangements should be made to provide stipends, transportation, and child care[1]. Consequently, dedicated funding should ideally be available to ensure necessary supports for the consumer input, education, and mentoring needed to facilitate meaningful participation.

Accessibility

Person-centered care means that accessibility of services and accommodations should be considered more broadly, and inclusive of physical and geographic accessibility as measured in the time and distance to integrated setting. Telehealth services can improve access, especially in areas that are geographically dispersed, rural, or where professional shortages make on-site services challenging.

Whether in-person or remote, services should be culturally and linguistically appropriate. They should be considerate of reading proficiency levels and health literacy. They should also be psychologically and emotionally accessible for any patient. Accountability to providing these culturally appropriate services is essential and should be continuously monitored. Culturally appropriate services will vary depending on the communities that receive services and the provider type.

Trauma-Informed

A trauma-informed approach is defined by SAMHSA as one 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]

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[1] Many examples 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
http://www.communitycatalyst.org/doc-store/publications/a-seat-at-the-table-duals-consumer-engagement.pdf

Trauma-Informed Care (TIC) is the adoption of principles and practices that promote a culture of safety, empowerment, and healing which studies show promotes positive health outcomes.[2] An important nuance to keep in mind is that trauma-informed care should take seriously the harm people have previously experienced WITHIN the healthcare system and be responsive to that in delivery of services.

Evidence-Based

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

We wanted to leverage the lessons learned from the Primary and Behavioral Health Care Integration (PBHCI) SAMHSA/HRSA integration grantee evaluation reports. However, Learning Collaborative members described the difficulty "translating" research into practice. 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* has emerged as a separate body of research, distinct from clinical research. Translational research which has influenced the approach of the Learning Collaborative is aimed at enhancing the adoption of best practices in the community.[3]

Evaluation of proven or promising practices must also include an assessment of the fidelity and effectiveness of implementing certain practices from multiple perspectives, including the clinician and consumer perspectives. These perspectives are key to determining if practices actually fit within the current operational environment or clash with patient values, for example.

Finally, while evidence is often established among certain groups or specific settings, most behavioral health services are not a cookie cutter set of operations but rather a flexible array of services curated to meet the needs of diverse communities. Thus, implementing evidence-based practices should mimic this adaptability and be responsive to the changing circumstances of real-world consumers and providers as well as to research, underscoring the importance of continuously monitoring those practices.

Financially Sustainable

Even a model with a strong evidence-base and flexibility will not achieve long-term success if it is not financially sustainable.

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[2] http://www.integration.samhsa.gov/clinical-practice/trauma#trauma_informed_care
[3] 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]

Learning Collaborative members Heartland Health Centers, a federally qualified healthcare center (FQHC), and Trilogy Behavioral Healthcare, a community mental healthcare center (CMHC), shared lessons for financial sustainability from their integrated care partnership (part of the Primary Care and Behavioral Health Integration SAMHSA demonstration grant program). The full integration of Heartland and Trilogy—beyond co-location of services—requires moving towards financial sustainability, giving the Learning Collaborative the opportunity to examine the specific financial advantages to partnerships between FQHCs and CMHCs or other behavioral health providers.

Although Illinois passed on the chance to test Certified Community Behavioral Health Centers (CCBHCs) with prospective payment systems similar to FQHCs, we expect to see an increasing shift in payments from grants and fee-for-service (FFS) to various kinds of value-based payments. All practices will need to prove they can cost-effectively use the right people and services at the right time while identifying the financial return and value they produce for consumers, payers, and partners in the continuum of care.

The Learning Collaborative has considered various intermediate payment reforms that could bridge FFS and value-based payments such as moving braided funding to more seamlessly blended funding; reimbursement for care coordination, case management, and outreach services (Medicare now includes codes for chronic care management and transitional care management, for example); and flexibility in Rule 132 and block grants to allow multiple providers to bill for services during a single visit.

We also learned that an enhanced rate for people with SMI or SUD to pay for the time needed to provide person-centered and trauma-informed care is closer than we think. The notion that people with chronic conditions (such as SMI and SUD) need a different payment structure has taken hold in other states which are already implementing enhanced rates.

A change in types of payment models requires technical assistance for providers. This technical assistance should include information about various financial models, different streams of revenue, legal requirements for information sharing between providers, and how to measure costs and outcomes to report performance under value-based payment models. Of course, a truly cost-effective program meets the needs of the consumer as well as cost targets, so financial strategies and monetary incentives must not overwhelm the influence of the consumer in the delivery of care.

Core Services[4]

The Learning Collaborative agreed that an integrated practice must provide, either directly or through referrals, the core services necessary to meet the needs of the people it serves. We used the CCBHC required services list as a starting point to identify a practical, comprehensive list of Core Services that define the parameters of an integrated practice:

1. Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization

2. Screening, assessment and diagnosis including risk assessment

3. Patient-Centered treatment planning or similar processes, including risk assessment and crisis planning

4. Outpatient mental health and substance use services

5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk

6. Targeted case management

7. Psychiatric rehabilitation services

8. Peer support and counselor services and family supports

9. Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

> *According to the CCBHC certification criteria for non-four-walls system design, the traditional four-wall approach to health care delivery must be reconsidered because many people with the highest needs often:*
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> - *Cannot come to an on-site facility to receive the care they need*
> - *Require novel methods of care to integrate behavioral and physical health, and appropriately manage care*
> - *Require interventions that include community involvement and education—particularly individuals with substance use disorder*

Many of these services are not simple, discrete service lines that can be quickly implemented or purchased. Several are enormous challenges facing the entire delivery system. For instance, developing and implementing person-centered service plans and utilizing peer support effectively and sustainably are Core Services that will not be reached without system-level reform and

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[4] Note that the State of Illinois's 1115 Waiver Application refers 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."

significant support for practice-level change. Learning Collaborative members also emphasized that support services for housing and employment, not specifically included in the nine CCBHC required services, are critical to stabilization and long-term recovery.

Workforce Standards

The Learning Collaborative focused our discussion of workforce standards on team-based care. We agreed that the workforce standards of integrated behavioral and primary healthcare teams must include traditional cultural diversity (including geriatric-competence) as well as behavioral health diversity.

Person-centered services involve individualized care and support delivered by a team of providers that are guided in their approach by the person receiving services. In team-based care, patients engage with multiple providers who ensure care continuity for the patient. A 'bench' of informed people in recovery should be built to develop expertise and provide mutual support and ensure that the planning and implementation of care teams is inclusive of and responsive to consumers' goals, values, preferences, and motivations.

Certified peer recovery specialists who have experienced mental illness or substance use disorders are effective at engaging their "peers" in their own self-care and are valuable additions to a care team. To support the evidence-based utilization of peer support and to facilitate culture change within practices, it is important for providers to employ—and payers to reimburse—peer support workers.

Effective training and ongoing support and supervision for all team members are essential to successful integrated care. Missouri, Washington, and other states offer lessons for this, including the use of Practice Coaches for health home sites, cross-training medical and behavioral health staff, and technical assistance for managing per-member-per-month payments.

Integrated models may need specific support to adapt to the requirements of "empanelment," in which 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.[5]

Furthermore, an integrated workforce may require expanded scope of practice for various professionals (i.e., APNs, RNs), which requires additional training and supervision. We found that one of the main challenges is securing sufficient funding for staff orientation and clinical supervision (both direct costs of training and staff time for attending supervisory meetings).

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[5] Safety Net Medical Home Initiative, http://www.safetynetmedicalhome.org/change-concepts/empanelment

Technology Standards

Health Information Technology (HIT) is vital in monitoring and improving outcomes through electronic health records and performance dashboards, engaging consumers in decision-making, as well as integration and coordination of care. However, this is a particularly challenging criterion because there are huge disparities in technology systems among provider sites, with some lacking electronic record systems entirely. Moreover, if HIT is a tool to support 'whole person care,' we need to develop better ways to track utilization, outcomes, and costs from community and social supports providers along with medical information.

A common concern in Learning Collaborative discussions is that there is not enough large-scale public infrastructure investment in health information exchange. Communication of personal information across thousands of providers, payers, and consumers that is secure, accurate, and timely is an enormous, system-level challenge. Individual provider organizations can, at best, create small-scale solutions to share information with a particular network of partners, and even those projects carry the risk that a data system installed today will prove to be incompatible with a partner's system tomorrow. We continue to explore incremental solutions from various sources including the Medical Home Network's MHNConnect portal, existing regional information exchanges, and MCOs, which are skeptical about sharing information with their competitors in a data repository, but might share some actionable data with providers in their networks.

Amid the concerns about technical barriers to information exchange we must not neglect the privacy and confidentiality concerns of consumers. Care must be taken with all personal health information, and it is important to acknowledge stigma within health care professions that may cause consumers to be especially skeptical about sharing behavioral health information with other medical providers.

Conclusion

These six criteria define the goal of integration that the Learning 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. The process used by the Learning Collaborative is intended to be a continuous learning loop. The guiding set of principles will continue to be refined as pilot programs are realized, bringing to light the lessons that only real-world implementation can teach. 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.