

State Innovation Model (SIM) Grant Behavioral Health Integration

Background and Overview of Models

January 8, 2016



West Virginia
STATE INNOVATION
MODEL GRANT

Overview of Today's Presentation

- The context of current health care in West Virginia and nationally
- What is Integrated Behavioral Health and Primary Care?
- Why should we integrate BH and PC?
- How does integrated care work in practice?
- What approaches are we recommending for consideration in West Virginia?
- Questions, Discussion, and Reactions

U.S. Healthcare costs too much, wastes too much, and yields poor outcomes

- 30 percent of all Medicare clinical care spending is unnecessary or harmful and could be avoided without worsening health outcomes—Dartmouth
- \$690 billion was wasted in US health care annually, not including fraud—Institute of Medicine, 2012
- “Much [of the] waste is driven by the way US health care is organized, delivered, and paid for and, in particular, by the economic incentives in the system that favor volume over value.”—Health Affairs, 2012
- U.S. health care ranks last or near last on dimensions of access, efficiency, and equity—Commonwealth Fund, 2014

Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume—Goal for Medicare, Medicaid reform

- “A major cause of the high cost of health care in America and of many of the serious quality problems in health care is the way healthcare providers are paid.” (Harold Miller, MD)
- “We’ve had no success over the years convincing providers to make changes that weren’t in their financial self interest” (Paraphrase of Bruce Bagley, MD, CEO of TransforMED)
- By 2018, CMS plans to have 50% of all Medicare payment by Alternative Payment Models.
- Movement to Value Based Payment is a key goal of CMS

The Context in West Virginia

- Poor population health—consistently among the worst on both health conditions and BH indicators
 - Highest opiate overdose rate in the nation
 - West Virginia’s suicide rate is higher than any surrounding state
 - 16.4 deaths per 100,000
- Challenges with hiring & retaining primary care and BH providers -- Even greater challenges with geographic distribution of providers in rural state
- Relatively high spending on health care (12th in the nation; 113% of national average in 2009);
- Modestly below average spending on BH care (rank 30th among States; 78% of national average in 2013)

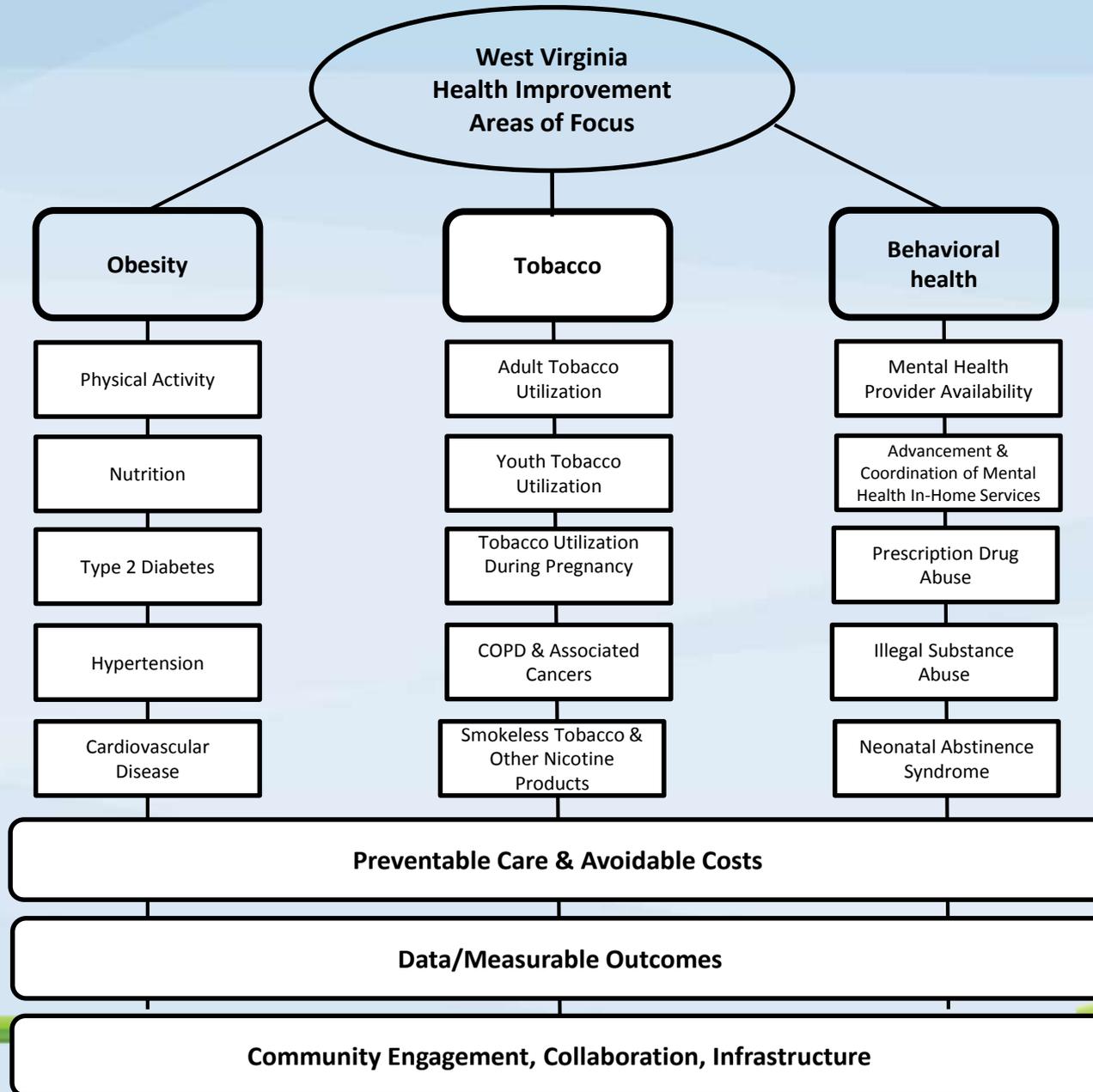
The Context in West Virginia, cont.

- Recently moved aggressively into managed care for Medicaid—BH only added in July 2015, so there's little claims history to inform decision making
- Four MCOs, each with differing quality measures, payment approaches, administrative requirements, approaches to behavioral health & care coordination
- Historically and until the present the system has relied almost totally on fee-for-service reimbursement
 - Providers have no experience with alternative payment approaches and difficulty envisioning the future in which payment is tied to value

The Context in West Virginia, cont.

- Examples of many promising practices around the State, but most are limited in scope
 - Care coordination, complex care management, super utilizers, CHWs, etc.
- Some innovative practices started with grants, then end when the grant expires (e.g., use of Recovery App for people with substance use disorders)
- A few FQHCs and CMHCs collaborating to provide whole person care (e.g., SAMHSA PBHCI grants)
- Several FQHCs providing behavioral health services, although the degree of integration not clear

Major Health Issues in West Virginia



What is Behavioral Health Integration?

Behavioral health integration refers to the care from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

This care may address:

- mental health and substance abuse conditions,
- health behaviors (including their contribution to chronic medical illnesses),
- life stressors and crises, stress-related physical symptoms, and
- ineffective patterns of health care utilization.

The Lexicon

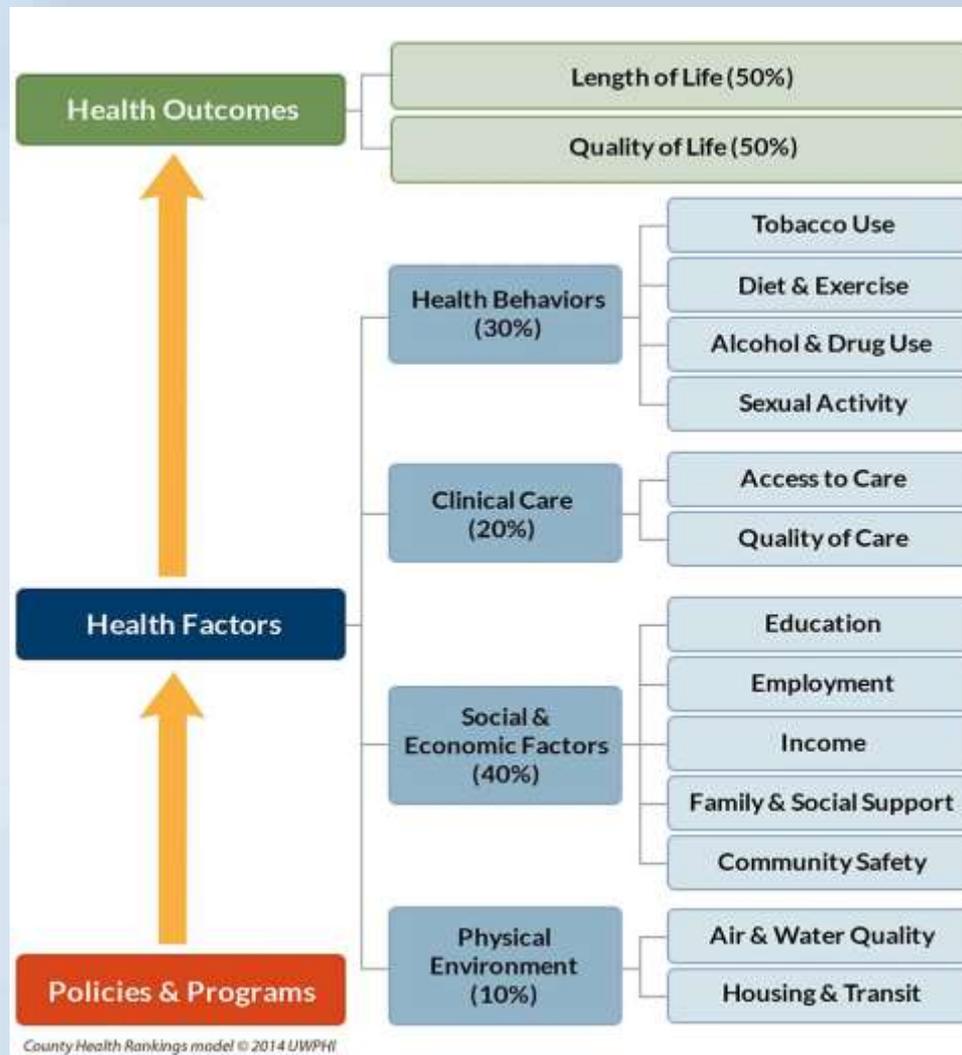
Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by Expert Consensus

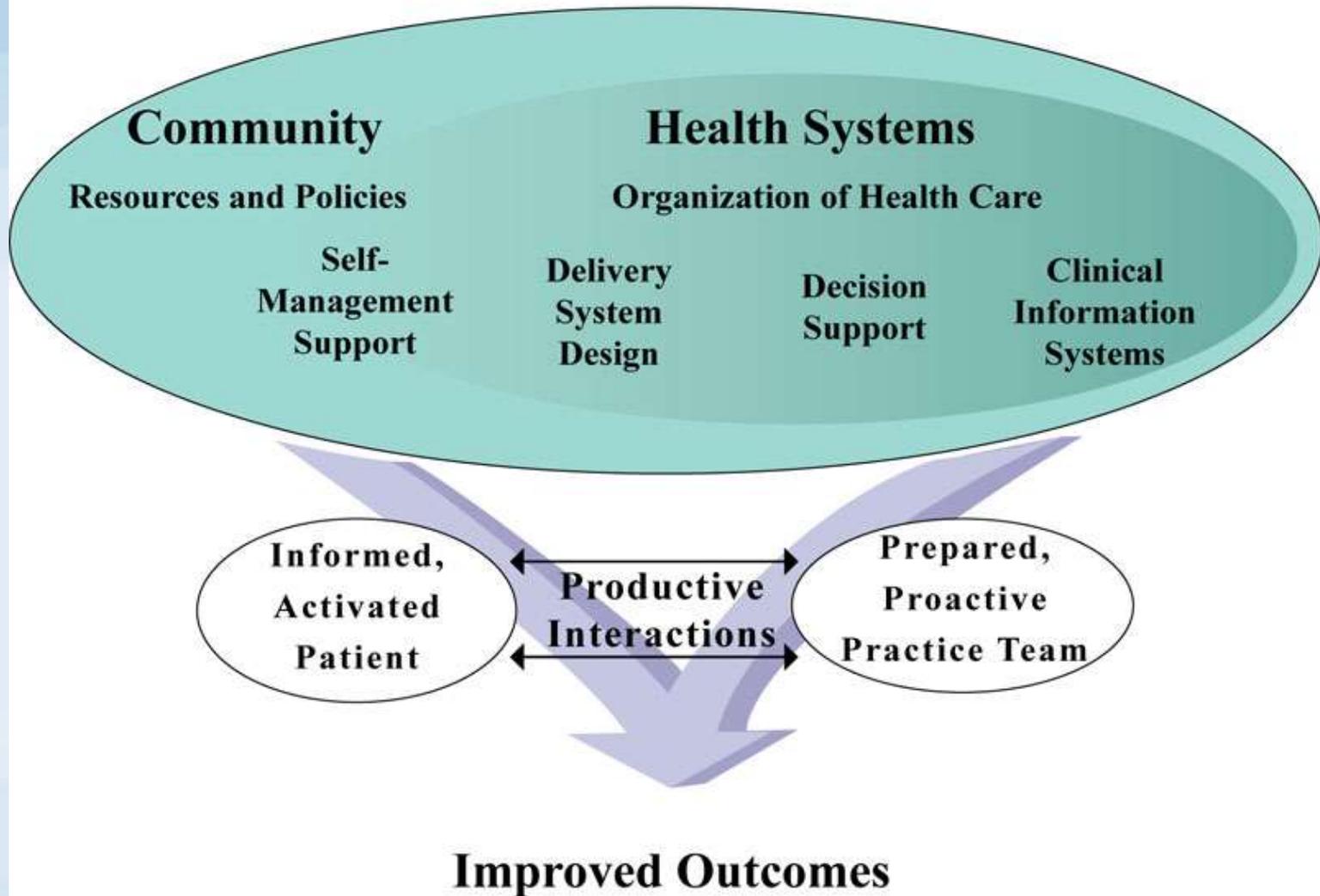


Important Role of Non-clinical Determinants

<http://www.countyhealthrankings.org/resources/county-health-rankings-model>



The Chronic Care Model



Developed by The MacColl Institute
© ACP-ASIM Journals and Books

Burden of Mental Illness

- One in 4 Americans struggle with a mental health or substance use problem at some point in their lives. No family goes untouched.
- Mental disorders are responsible for about **25 % of all disability worldwide**
 - Depression alone accounts for 10% of health related disability.
 - Years Lost to Disability (YLD) from depression are 3x diabetes; 8x heart disease; 40x cancer

(Murray C et al; Global Burden of Disease ; Lancet, 2012)

- For governments: high health care costs, high rates of unemployment, homelessness, and involvement in the criminal justice system.
- For employers, mental health & substance use problems are
 - Major drivers of absenteeism and presenteeism
 - Major drivers of health care costs, suicide

BH and High Health Care Costs

“. . . an estimated \$26 - \$48 billion can potentially be saved annually through effective integration of medical and behavioral services.”-APA Milliman Report

Population	% with behavioral health diagnosis	PMPM without BH diagnosis	PMPM with BH diagnosis	Increase in total PMPM with BH diagnosis
Commercial	14%	\$ 340	\$ 941	276 %
Medicare	9%	\$ 583	\$ 1429	245 %
Medicaid	21%	\$ 381	\$ 1301	341 %
All insurers	15%	\$ 397	\$ 1085	273 %

Mental health specialty care accounts for only 3 % of overall costs.

More effectively integrated mental health care could save billions.

** APA Milliman report; Melek et al; 2013*

Care for mental disorders

- 6/10 get NO CARE
- Of those who get care
 - **Only 2/10 see a trained mental health professional**
 - Most receive treatment in primary care
 - 30 million receive a prescription for a psychiatric medication in primary care
 - Only 1/4 improve
- 2/3 PCPs report poor access to mental health services for their patients
- More than half of counties in US don't have a single practicing MH professional

Example: Depression

Common

1 diagnosis in mental health
Common in primary care (10%)

Disabling

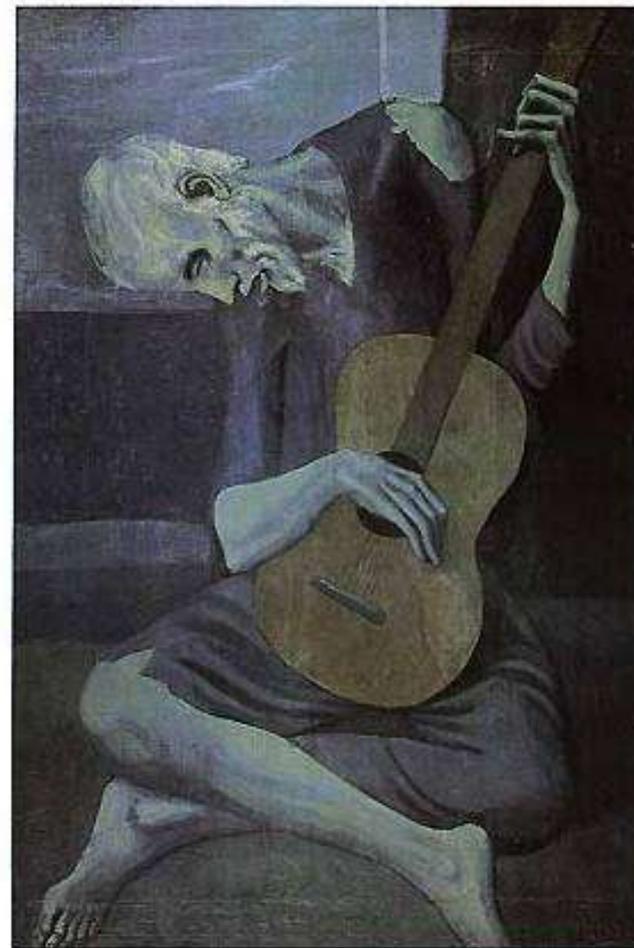
10 % of all health-related disability

Expensive

50-100% higher health care costs
Lost productivity

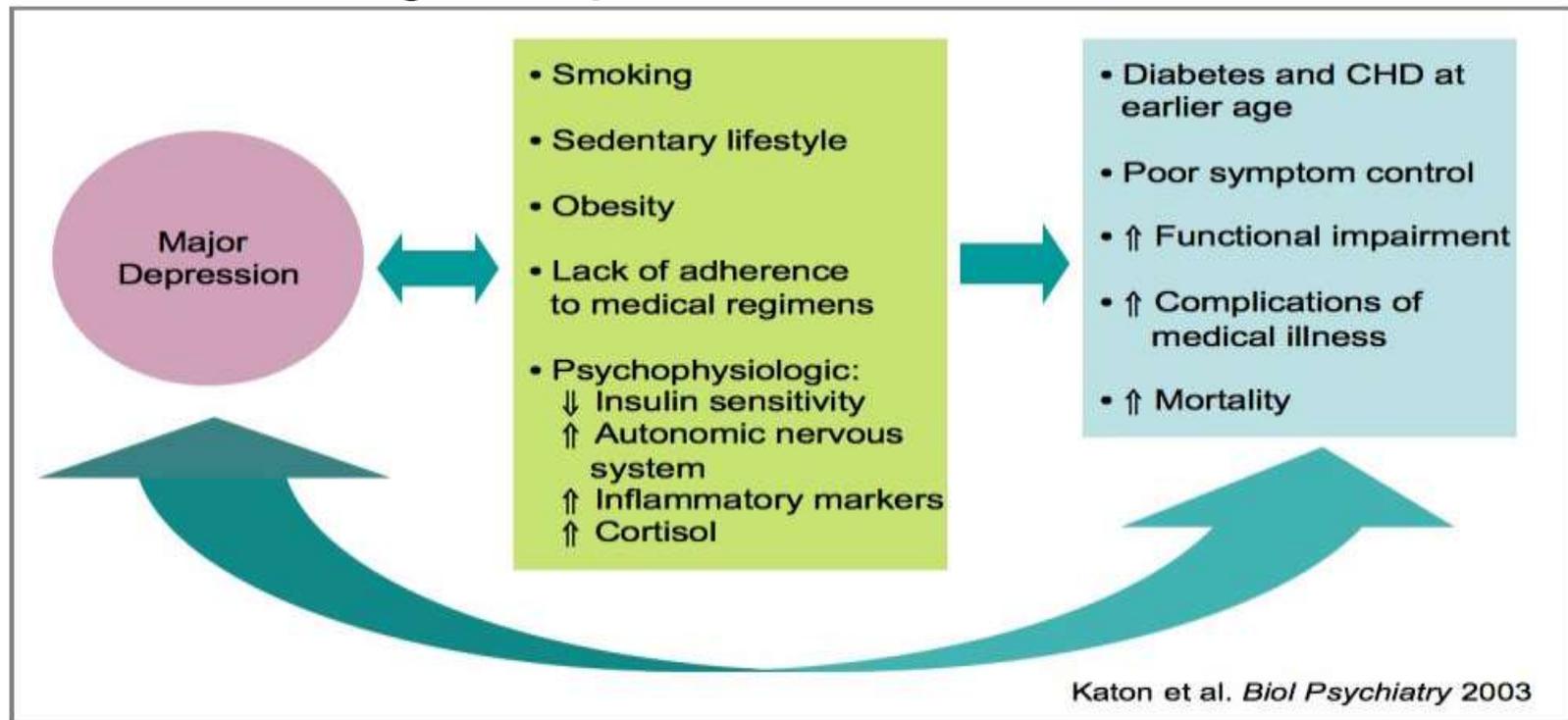
Deadly

Over 30,000 suicides / year



Mental and Medical Disorders are tightly linked

e.g., Depression & Diabetes



Caring for the Whole Person takes a Team That Works Together



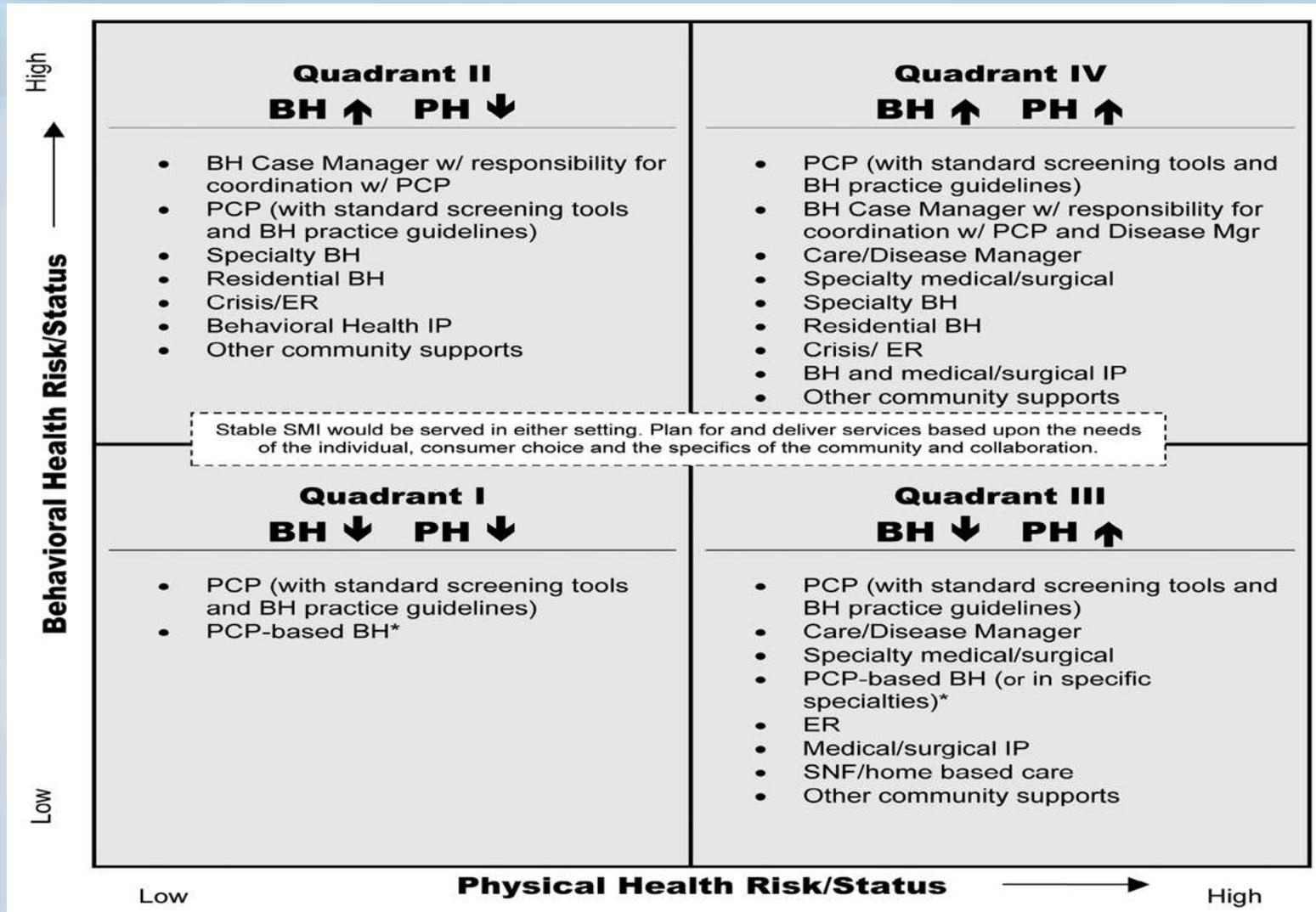
Thanks to the California Integrated Behavioral Health Project: <http://www.ibhp.org/>



Mental health and primary care are inseparable;
any attempts to separate the two leads to
inferior care

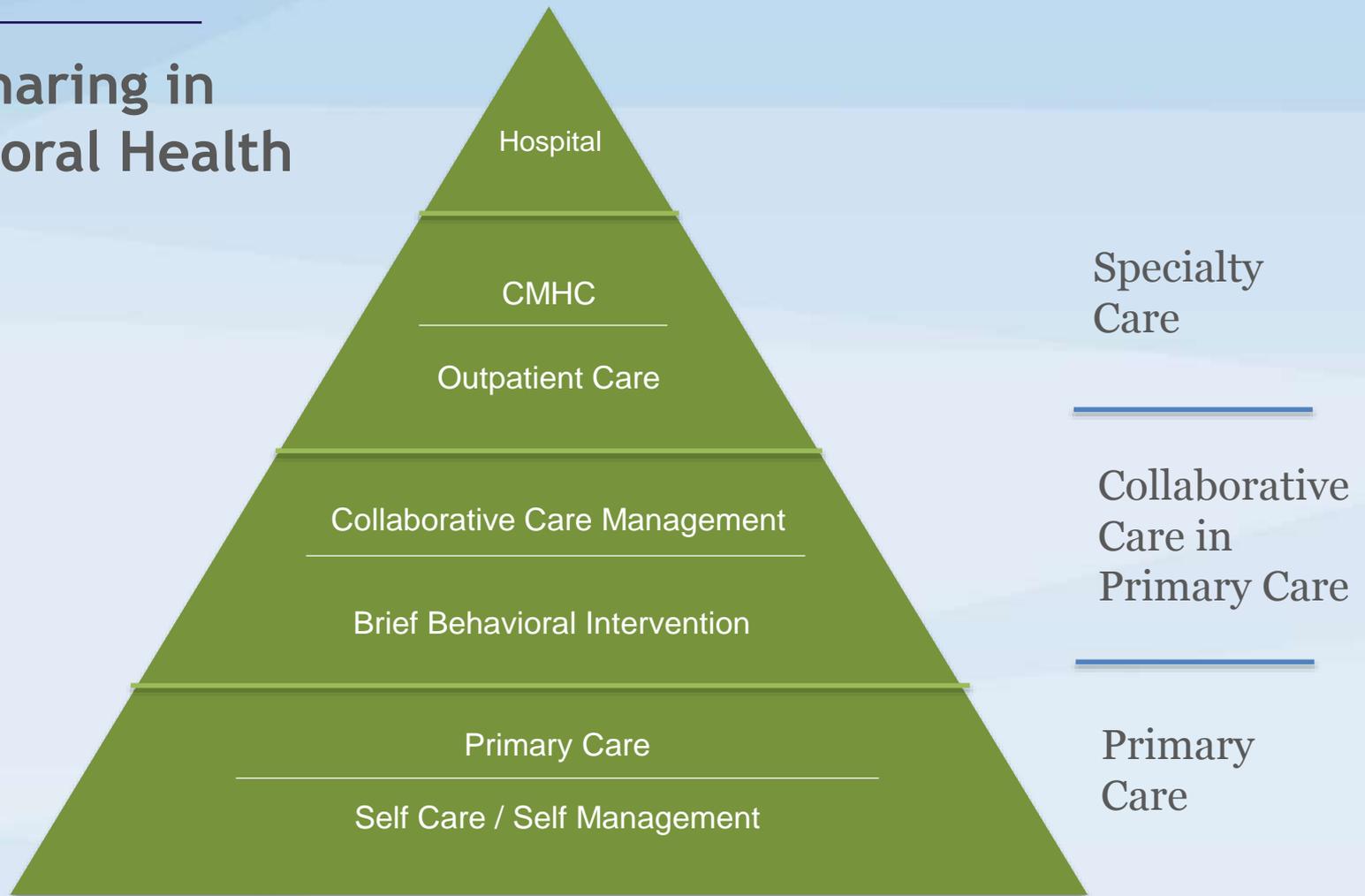
- Institute of Medicine, 1996

The Four Quadrant Clinical Integration Model



*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.

Task Sharing in Behavioral Health Care



Principles of Effective Integrated Behavioral Health Care

Patient-Centered Team Care / Collaborative Care

- Co-location is not Collaboration. Team members have to learn new skills to work effectively as a team in new roles

Population-Based Care

- Patients tracked in a registry: no one ‘falls through the cracks.’ Keeping track of clinical outcomes over time for the population served.

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are ‘evidence-based’ to the extent possible. Strategies also help to develop practice-based evidence to facilitate continual improvement over time.

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Fundamental Principles: Patient- (and Family-) Centered Care

- Relationship-based care that continues over time
- Consideration of patient goals and wishes
- Shared decision making
- Focus on health literacy, patient engagement, patient activation
- Consideration of patient resources and capabilities as part of planning
- Linkage to community resources and consideration of Social Determinants of Health

Fundamental Principles: Measurement and Tracking

- Measurement based care—continual monitoring of patient progress with standard tools
- Population based care—using registries to monitor progress of patient panels and evaluate overall strategy
- Treatment to Target and Stepped Care: Having clear goals and making adjustments to care plan if expected progress isn't seen over time
- Use of evidence-based care—relying on research and practice-based evidence

Fundamental Principles: Care Teams

- Well-coordinated Team-based care, with a care team tailored (as possible) to the needs of the patient
 - Team members will need training in how to function as a team
 - Likely to include new roles—such as Care Manager, Health Educator, and Community Health Worker/Peer Coach
 - Teams may be on site, virtual by telehealth, or a combination of both, as the circumstances dictate
 - Using telehealth to make specialized expertise more widely available, educate rural providers

Fundamental Principles: Community Linkage

- Linkage to available community resources, including:
 - Churches and community organizations
 - Schools and school-based health centers
 - Drug and mental health courts
 - Recovery community groups—AA, NA, mental health consumer groups
 - Wellness and fitness programs
 - Outreach to corrections and justice systems
 - Housing with supports as needed

Fundamental Principles: Accountable Care

- Providers are accountable and reimbursed for patient clinical outcomes and quality of care, not just the volume of care provided
- Due consideration to the cost effectiveness of clinical strategies and conservation of resources
- Payment models are designed to align the incentives for Value:
 - Improved patient experience
 - Improved quality of care
 - Conservation of resources
- Minimize (or eliminate) the role of Fee for Service!

Principles of Effective Integrated Behavioral Health Care

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WV Challenges to Achieving these Principles

- Extremely limited State resources
 - Hard to make investments in cost-saving innovations
- Relatively weak/early implementation of health information technology—EHRs and HIE
- Limited ability to analyze data to segment population
- Distribution and scarcity of providers
- History of provider-centered care and hard-walled silos
- Resistance to change and organizational rigidity

Questions About the Principles?



How do we close the gap?

- Train & retain more mental health professionals
 - Work smarter—Consider the efficiency of our approach!
 - Leverage mental health specialists more effectively
 - partnerships (e.g., primary care)
 - technology (e.g., telemedicine)
 - Integration of behavioral health care with primary care has several advantages:
 - Better access to care
 - Better health outcomes
 - Lower costs
- = the Triple Aim of health care reform

Examples of Integrated Care

- Collaborative Care (IMPACT, DIAMOND, Washington State Mental Health Improvement Program)
- Comprehensive Primary Care (SHAPE at Colorado's Rocky Mountain Health Plan)
- Combined FQHC/CMHC (Cherokee Health System)
- FQHC and CMHC Partnerships (PBHCI, Missouri, Washtenaw County)
- Integrated Comprehensive Health Systems (Intermountain Healthcare, Group Health of Puget Sound)
- Many others emerging and growing rapidly

Collaborative Care/Consulting Psychiatrist Model

- Very well suited for mild to moderate BH disabilities (depression, anxiety, excessive drinking) in Primary Care (PC) settings
- Mid-level BH provider (MSW, MA psychologist or counselor), called the Care Manager, joins team in partnership with the PCP
- Use evidence-based brief cognitively oriented psychotherapies (PST, ACT, SBIRT)
- Progress is monitored by regular measurement (PHQ-9, GAD-7, AUDIT, etc.) and recorded in an online registry

Collaborative Care



Primary Care Practice with Mental Health Care Manager



Outcome Measures



Treatment Protocols



Population Registry



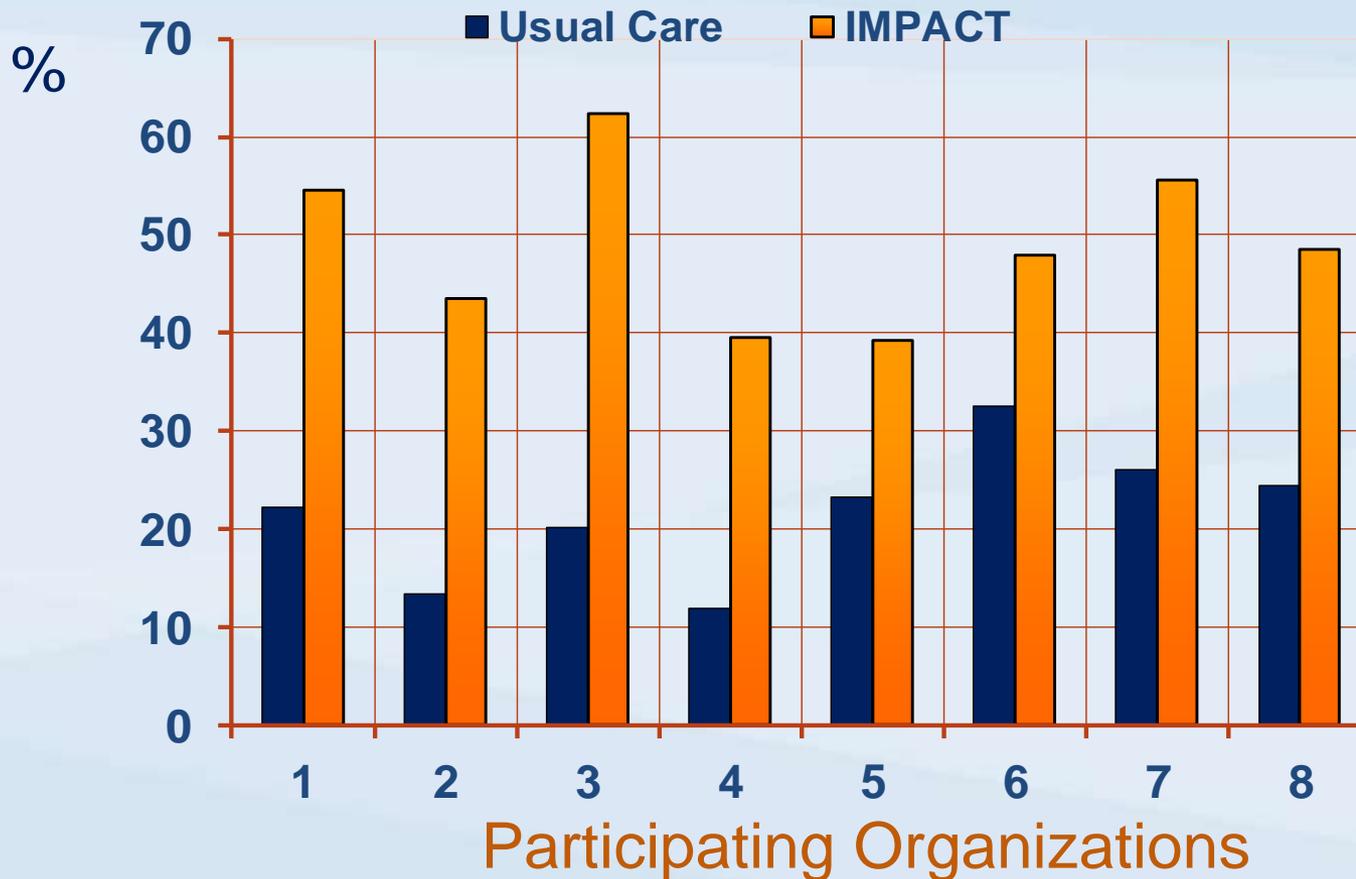
Psychiatric Consultation

Collaborative Care/Consulting Psychiatrist Model, cont.

- Care Manager and Psychiatrist regularly review the care registry and identify changes in clinical regimen if patients aren't improving as expected
- Consulting psychiatrist works with Care Manager and advises the PCP on medication choices and the Care Manager on therapeutic strategies
- Psychiatrist time is focused on patients not improving as expected—Treatment to Target, Stepped Care
- Model proven to be effective & cost effective in 80+ randomized clinical trials over 20 years

Integrated Care doubles effectiveness of care for depression

50 % or greater improvement in depression at 12 months



Integrated Care reduces health care costs

ROI: \$ 6.5 saved / \$ 1 invested

Cost Category	4-year costs in \$	Intervention group cost in \$	Usual care group cost in \$	Difference in \$
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	31,082	29,422	32,785	-\$3363

Savings



Replication studies show: *the model is 'robust' across clinical problems*

Clinical Setting	Target Clinical Conditions	Reference
Primary Care for Adolescents	Adolescent Depression	Richardson 2009, 2014
Adult primary care	Depression & Diabetes Depression, Diabetes, Heart Disease	Katon et al., 2004 Katon et al, 2010
Latino patients in safety net clinics	Diabetes and depression	Gilmer et al., 2008 Ell et al 2010
Public sector oncology clinic	Cancer and depression	Ell et al., 2010
Women's health care clinics (IDAWN)	Depression, PTSD	Melville 2014 Katon 2014
Adult primary care	Anxiety Disorders including PTSD	Roy-Byrne et al 2012
Older adults in primary care	Arthritis and depression	Unützer et al., 2008
Primary Care / Cardiology (COPES)	Heart disease and depression	Davidson et al., 2010

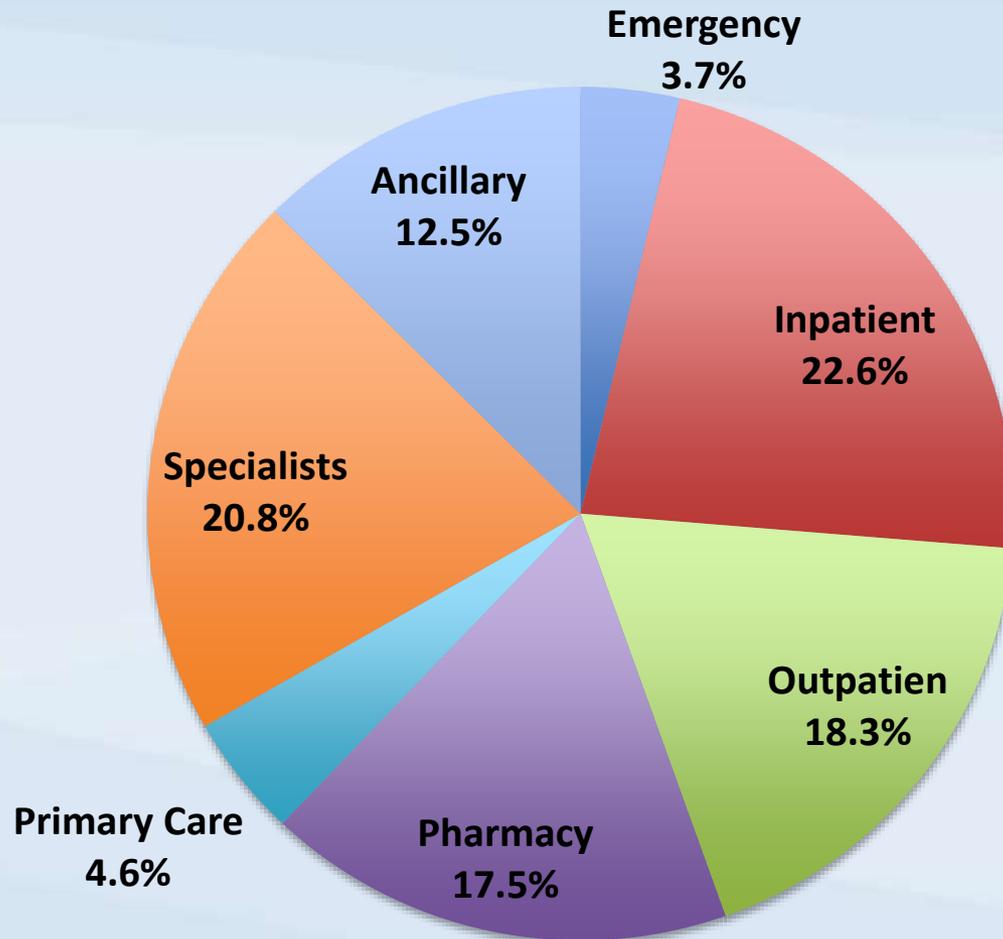
UW MHIP Psychiatric Consultant

Centralia, WA - October 2013

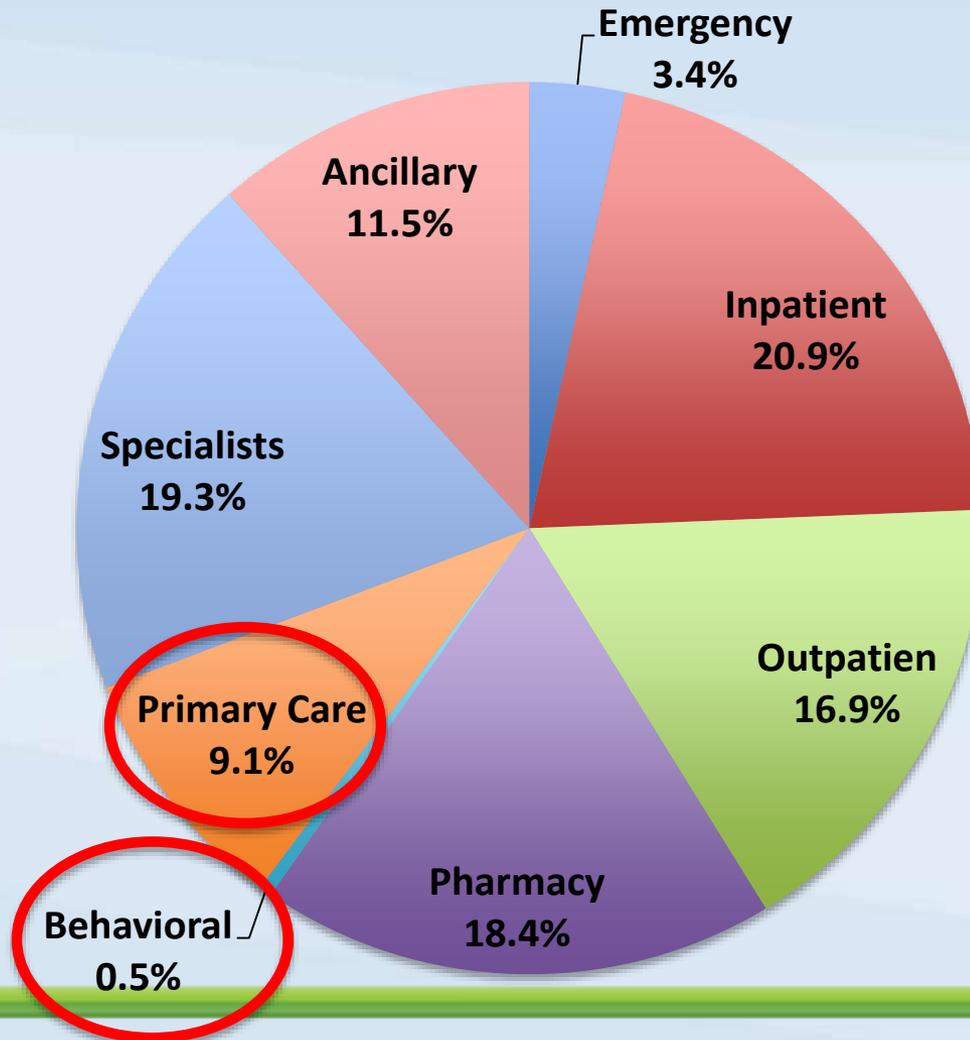
Over 45,000 case reviews/consultations since 2008:
MHIP is a great way to build capacity in our provider community.

“The greatest benefit of the MHIP consultation program may be in the diagnosis and treatment of patients that aren’t even in the program.”

Global Budget - Conventional Network—Rocky Mountain Health Plan, SHAPE Project—BEFORE



Global Budget - Integrated Practices—Rocky Mountain Health Plan, SHAPE Project—**AFTER**



Bi-Directional Integration (Missouri)

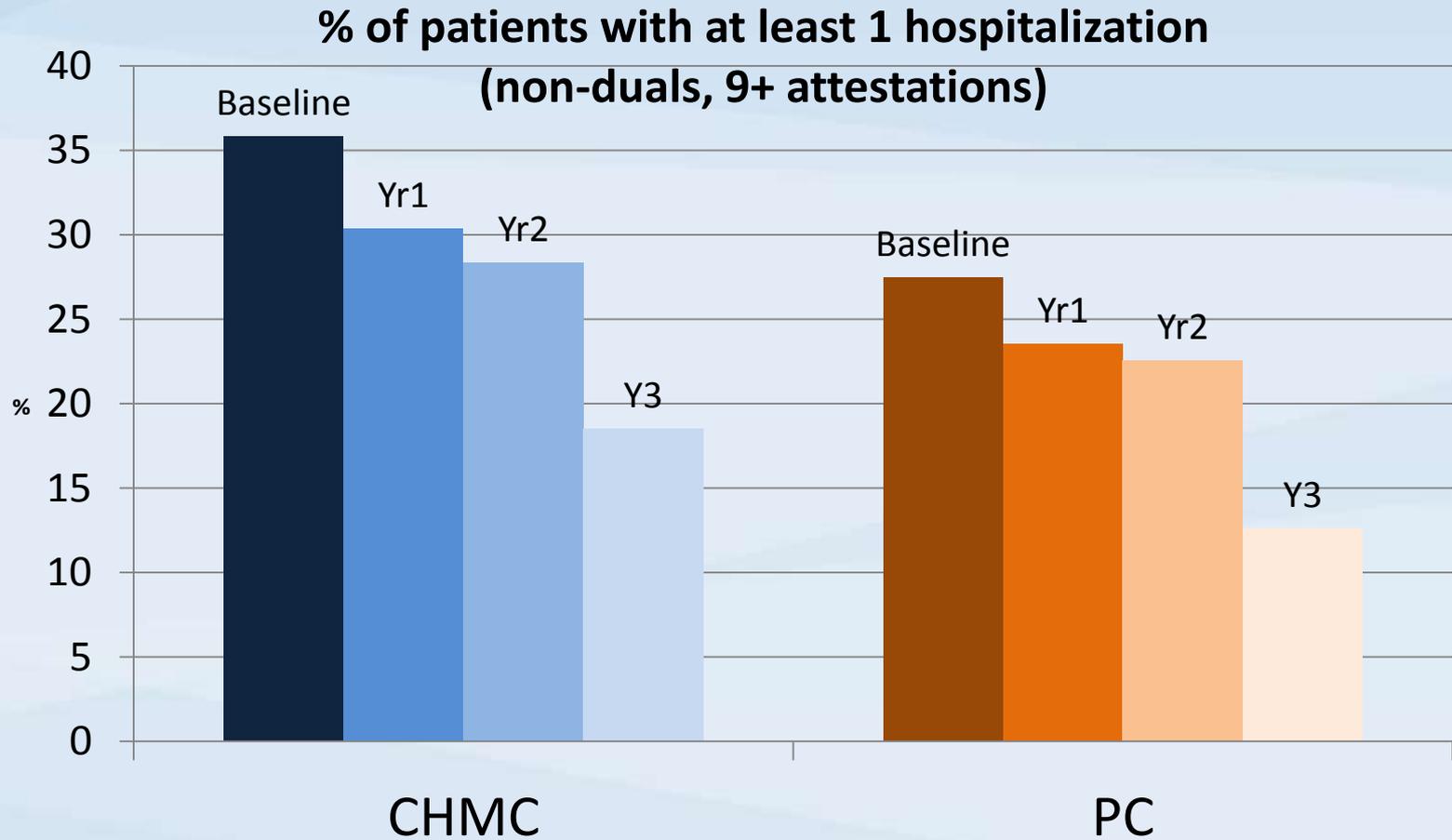
Primary Care Health Homes

- Behavioral Health Consultants
- SBIRT (web-based)
- PHQ 2 screening
- 6 of 20 Quality Performance Measures are BH
- 4 of 8 Medication adherence measures are BH
- BH prescribing benchmarking and feedback

CMHC Healthcare Homes

- Primary Care Consultants
- Primary Care Nurse Care Managers
- Annual+ Metabolic Screening
- Diabetes Education
- 10 of 20 Quality Performance Measures are Medical
- 4 of 8 Medication adherence measures are medical

Outcomes: Reducing Hospitalization (Missouri)



Initial Estimated Cost Savings after 18 Months (Missouri)

- PC Health Homes
 - 23,354 persons total served (includes Dual Eligibles)
 - Cost Decreased by \$30.79 PMPM
 - Total Cost Reduction \$7.4 M

- CMHC Health Homes
 - 20,031 persons total served (includes Dual Eligibles)
 - Cost Decreased by \$76.33 PMPM
 - Total Cost Reduction \$15.7 M

FQHC/CMHC Integration Initiative (Missouri)

- Ongoing since 2008
- Seven PC/BH ongoing partnerships (\$200K) funded
 - BH services on-site at PC clinic by CMHC
 - PC services on-site at CMHC by PC clinic
- More Organizations are both CMHC and PC
 - Five CMHCs obtained new FQHC status
 - One merger of a CMHC with a FQHC
 - One CMHC acquired a RHC
- More FQHCs have chosen to contract with CMHCs for BH services at other sites beyond the grant rather than develop their own BH services

Project ECHO Model

- Educational model that supports capacity building for challenging healthcare problems
 - University based specialists in complex chronic health problems use a case-based learning model to educate rural/remote providers on evidence based care regimens
 - First WV implementation starting, with Benedum support
- Relatively low cost strategy for improving care quality and making specialist knowledge available in remote areas
- Geographically distributed partner organizations offer ECHO hardware/software and local care teams, as appropriate to the patient characteristics

Consider Project ECHO Model for groups like:

- Hepatitis C (already starting—Cabin Creek & WVU)
- Complex health conditions/high cost/high utilizers (typically including behavioral illnesses)
- Opioid Addiction
- Chronic Pain
- Serious mental illnesses
- Children and youth with serious emotional disturbances
- Early Intervention in Youth with Psychosis
- Geriatric care

Project ECHO Model, cont.

- Consider partnerships with school-based health centers to integrate BH care for youth with SED or early stage psychotic disorders
- In New Mexico, the ECHO model has also been used to train nurses and community health workers
- New Mexico has dramatically increased the number of PCPs trained in the use of buprenorphine to treat opioid addiction
- ECHO has been adopted by the VA, the DOD, states all over the country, nations all over the world—aiming to improve care to a billion people

Organizational Strategies, Supported by Telehealth

- Expanded use of Medicaid Health Homes, especially for complex, costly patients
- Expanded implementation of Patient Centered Medical Homes–Level 3 that integrate BH and Primary Care
- Expanded partnerships of FQHCs and CMHCs to provide integrated care across the Four Quadrants
- Consideration of Mergers of FQHCs and CMHCs to provide integrated care for all populations
- Increased use of innovative technologies to improve care access and quality, cost effectiveness

WV Based Resources to Support Change

- WV DHHR
- WV Colleges and Universities
- Managed Care Organizations
- Provider Associations
- Demonstration projects currently underway
- Regional Groups of health care and social service providers
- Non-profit groups working to improve healthcare
- Companies that offer services relevant to goals

Additional Resource to Support Implementation: The AHRQ Academy

- The Academy for Integrating Behavioral Health and Primary Care
- A national resource center for the integration of behavioral health and primary care
- Established in 2010 with AHRQ funding
- Taken shape with guidance from a national expert panel, the NIAC

www.integrationacademy.ahrq.gov/

Academy Portal

<http://integrationacademy.ahrq.gov/>

The screenshot shows the top navigation bar with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below this is the AHRQ logo and the text "Agency for Healthcare Research and Quality" and "Advancing Excellence in Health Care". The main header features "The Academy" logo and the tagline "Integrating Behavioral Health and Primary Care". A search bar and social media links are also present. A green navigation menu includes links for Home, About Us, Research, Education & Workforce, Policy & Financing, Lexicon, Clinical & Community, Health IT, Resources, and Collaboration. The main content area has a "Now Available!" section with a link to "Learn More About Professional Practices for Integration". A "Vision" section states: "AHRQ's vision is that the Academy for Integrating Behavioral Health and Primary Care will function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare." Below this is a "Welcome to the Academy" section with a paragraph: "The AHRQ Academy web portal offers you resources to advance the integration of behavioral health and primary care, and fosters a collaborative environment for dialogue and discussion among relevant thought leaders." The bottom section is divided into four columns: "What is Behavioral Health Integration?" with a brief definition; "Where Integration is Happening" with a map of the United States and a "Learn More..." link; "New & Notable" with a list of recent news items; and "Featured Products" with links to "Professional Practices: Key Competencies for Integrated Care Delivery", "Atlas of Integrated Behavioral Health Care Quality Measures", and "LEXICON for Behavioral Health and Primary Care Integration".

U.S. Department of Health & Human Services www.hhs.gov

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

The Academy
Integrating Behavioral Health and Primary Care

Search - A A+

Connect with us: [f](#) [t](#)

Home About Us Research Education & Workforce Policy & Financing Lexicon Clinical & Community Health IT Resources Collaboration

Now Available!
Access the Professional Practices: Key Competencies for Integrated Care Delivery and literature review
[Learn More About Professional Practices for Integration](#)

Vision
AHRQ's vision is that the Academy for Integrating Behavioral Health and Primary Care will function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare.

Welcome to the Academy
The AHRQ Academy web portal offers you resources to advance the integration of **behavioral health and primary care**, and fosters a **collaborative** environment for dialogue and discussion among relevant thought leaders.

What is Behavioral Health Integration?
[Behavioral Health integration is] the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and c...
more ...

Where Integration is Happening
[Learn More...](#)

New & Notable

- Fri, 07/10/15 Get your Latest News via the Academy
- Fri, 07/10/15 2014 Healthcare Quality and Disparities Report and Resources
- Fri, 07/10/15 Cultural Competencies and Diversity Matter in the

Featured Products

- [Professional Practices: Key Competencies for Integrated Care Delivery](#)
- [Atlas of Integrated Behavioral Health Care Quality Measures](#)
- [LEXICON for Behavioral Health and Primary Care Integration](#)

Welcome to the Playbook

A guide to integrating behavioral health in primary care and other ambulatory care settings. To aid in improving health care delivery in order to achieve better patient health outcomes.

John Doe

john-doe@example.org
Edit Account | Log-Out

My Bookmark 

Planning for Integration
Define your Vision

 My Notes

Home

Playbook

Using the Playbook

Self-Assessment
Checklist

Planning for Integration

Implementing the Plan

Observations from
Exemplar Sites

What Not to Do

F.A.Q.

Connect with the
Community

 My Account

✓ Self-Assessment

You haven't taken the Self-Assessment Checklist.

Discover which key functions of integrated behavioral health care are already in place, and which are not. The checklist can help you decide where to focus your attention when you begin your implementation efforts.

Take Assessment >



Notes

You don't have any notes saved.

Notes allow you to keep notes while you go through the playbook. Including



Home

Playbook

Using the Playbook

Self-Assessment

Checklist

My Results

Planning for Integration

Implementing the Plan

What Not to Do

F.A.Q.

Connect with the
Community

 My Account



Welcome John Doe

Go to account

Complete/Edit Profile

Messages

Notifications

Logout

Self-Assessment Checklist Results

Results History ▾

 Print

 Update Assessment

Started: November 27, 2014 | **Last Update:** July 6, 2014

STATUS

 In Place

 In Progress

 Not Started

Instructions: Expand the sections below to get Playbook guidance for questions within the section. As you continue to implement integration into your setting, update your responses to assess your progress and identify areas for additional improvement.

Results by Section:

A Plan for Integrating Behavioral Health and Ambulatory Care

SHOW >

Operational Systems to Support Integration

SHOW >

Financial Support for Providing Integrated Behavioral Health and Ambulatory Care

SHOW >

Data for Patient Identification and Practice Improvement

SHOW >

Patient and Family Education

SHOW >

Academy Community




Agency for Healthcare Research and Quality
Advancing Excellence in Health Care



The Academy
Integrating Behavioral Health and Primary Care

Connect with us:  

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Research
Education & Workforce
Policy & Financing
Practice
Clinical & Community
Health IT
Resources
Collaboration

Welcome to the Academy Community

The Academy Community is a platform to connect, network, and share experiences. See what's being discussed in the discussion forums and join the interactive NIAC Chats.

Start The Tour
Logout


Where Integration is Happening
Learn More...

Collaboration

Groups

People

Whats Going On

All
Posts
Polls
Q&A
Create A Post



Post: The Academy Community Resources
7 hours ago | Glynis Jones

Visit the Resources on the portal to download the tools and strategies: <http://integrationacademy.ahrq.gov/evaluationtools>.



Post: Lorem ipsum dolor sit amet, consectetur adipiscing
8 hours ago | Jon Reid

Hendrerit neque leo eget tortor ut ultricies iaculis urna, ut hendrerit tellus faucibus ut. Suspendisse eu eros erat interdum.



Post: Suspendisse iaculis sollicitudin fermentum.
12 hours ago | Jon Reid

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Poll: Lorem ipsum magnis dis parturient montes?
2 months ago | Jon Reid

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Suspendisse

Event Calendar

NIAC Chat with Mscaran (Mac) Baird, MD, MS
October 26, 2014, 12:00pm - 1:00pm EST
1 attendees 0 comments

October 2014						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
24	25	26	27	28	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Recent Activity

Alexander Blount, Posted a new Discussion Topic - **The Academy Q&A Process**
2 hours ago

Aliquam ullamcorper magna eget accumsan commodo

Discussions

See All Discussions



Proin bibendum libero eget risus pulvinar, non porttitor ligula mollis.

2 hours ago | Glynis Jones

Cras nec odio nec enim venenatis sagittis. Aliquam erat volutpat mauris mollis congue nulla, in semper mauris vitae aenean gravida.



Phasellus nulla arcu, venenatis gravida risus eu, pretium iaculis purus.

3 hours ago | Glen Gillette

Nulla vehicula diam consequat quam interdum molestie. Mauris vel posuere nulla. Fusce varius quis sapien sed venenatis.



Quisque ut velit ut ante faucibus pharetra.

6 hours ago | Glen Gillette

Irisitque senectus et natus et malesuada fames ac turpis egestas. Donec eu venenatis leo donec eget ipsum a justo.

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Terry Bosley Posted a new Discussion

Topic - **Lacus leo dignissim quam, at gravida tortor sem nec odio.**

10 hours ago

Thomas Sanaki Posted a new Discussion

Topic - **Vivamus in ornare est sed ac lectus molestie, interdum lectus quis.**

11 hours ago



The Academy
Integrating Behavioral
Health and Primary Care

Including Implementation Guide, Curricula

The screenshot displays the AIMS Center website. At the top left, the AIMS Center logo is followed by the text "Advancing Integrated Mental Health Solutions". To the right, the University of Washington logo and "UNIVERSITY OF WASHINGTON, PSYCHIATRY & BEHAVIORAL SCIENCES DIVISION OF INTEGRATED CARE & PUBLIC HEALTH" are visible, along with the IMPACT logo. A navigation bar contains "WHO WE ARE", "WHAT WE DO", "COLLABORATIVE CARE", and a search box. A left sidebar lists menu items: "EVIDENCE BASE", "CORE PRINCIPLES", "TEAM STRUCTURE", "DOLLARS & SENSE", "STORIES", "RESOURCE LIBRARY", "IMPLEMENTATION GUIDE" (highlighted), "STEP 1: LAY THE FOUNDATION", "STEP 2: PLAN FOR CLINICAL PRACTICE CHANGE", "STEP 3: BUILD YOUR CLINICAL SKILLS", "STEP 4: LAUNCH YOUR CARE", and "STEP 5: NURTURE YOUR CARE". Below the sidebar is a "QUICK LINKS" section with "RESOURCE LIBRARY", "IMPLEMENTATION GUIDE", and "AIMS CENTER NEWSLETTER". The main content area features a "IMPLEMENTATION GUIDE" header with a five-step arrow diagram. The first step, "STEP 1", is highlighted in yellow. Below this is the heading "WELCOME TO THE COLLABORATIVE CARE IMPLEMENTATION GUIDE" and a paragraph: "This guide is an introduction to the process of implementing Collaborative Care, from the crucial first step of understanding what it is to monitoring outcomes once Collaborative Care is in place. Each step contains learning objectives along with materials to help you achieve them." A second paragraph states: "It's important to understand that implementing Collaborative Care necessitates practice change on multiple levels. It is nothing short of a new way to practice medicine and requires an openness to doing things differently. We hope this free guide helps you understand the scope of work involved and provides you with the tools you need to get started. The AIMS Center offers in-depth coaching and training that goes far beyond the contents of this guide and we encourage you to contact us to learn more." A third paragraph notes: "Because we continually learn from the organizations we work with, we are constantly refining our materials and adding new tools. Check back often to see what's new or subscribe to our newsletter to receive monthly updates." The final paragraph says: "For a printed overview of our Implementation Guide, see our Collaborative Care Implementation Guide."

Project ECHO Replication Support

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Become a Partner

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Our replication partners represent a variety of disciplines across the United States and the world. Every year, more partners find innovative ways to use the ECHO model to increase access and capacity to provide health and educational services.

Become a Replication Partner

- Becoming an ECHO replication partner requires the following:
 1. Learn more about ECHO to see if it fits your local needs and resources. Join one of our [training events](#) to learn more and explore the ECHO model.
 2. We ask that partners sign two documents: our [Statement of Collaboration for Replicating Partners](#) and our [Intellectual Property Terms of Use Agreement](#). The Terms of Use agreement needs to be customized for each individual partner. Please contact a Replication Program Coordinator at echoreplication@salud.unm.edu.
 3. Join us for Immersion training. This can be combined with the Orientation, especially for international partners. We ask that replication partners stay 3 days with us learning the specific best practices of implementing the ECHO model and running a successful teleECHO

SAMHSA-HRSA Center for Integrated Health Solutions

Making Integrated Care Work CONTACT US 202.684.7457

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ABOUT CIHS

SAMHSA-HRSA Center for Integrated Health Solutions

CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings.

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HOT TOPICS

- eSolutions
- Health IT
- Wellness
- Confidentiality
- Billing Tools
- Workflow
- Partnerships
- HRSA Supported Safety-Net Providers
- Motivational Interviewing
- Tobacco Cessation
- Screening Tools
- HRSA Supported HIV Providers

TOP RESOURCES

Key Elements of an Integrated System

- To address workforce shortages and maldistribution
 - Broaden support and remove barriers to use of telehealth
 - Project ECHO model using telehealth to make specialist expertise more broadly available throughout West Virginia
 - Collaborative Care/Consulting Psychiatrist model to improve treatment of common, less serious BH disorders in primary care
 - Broaden use of Community Health Workers, Health Educators, Peer Coaches for SUD, and Peer Services for MH—standardize training & certification
 - Revise academic curricula for health professions to support team-based models that integrate BH & primary care

Broader Three Level Telehealth Strategy

- **Level 1: Conventional Telehealth** (Saves travel, improves access)
 - Remove barriers to telehealth parity—allow its use anywhere, anytime; support patient contact site as well
- **Level 2: Collaborative Care/Consulting Psychiatrist Model** (Builds workforce capability over time)
 - Improve the quality & cost effectiveness of BH in primary care settings
- **Level 3: Project ECHO Model** (Educational model)
 - Makes specialized knowledge available to rural/remote providers—reducing isolation & enhancing their effectiveness

Organizational Strategies, Supported by Telehealth

- Expanded use of Medicaid Health Homes, especially for complex, costly patients
- Expanded implementation of Patient Centered Medical Homes—Level 3 that integrate BH and Primary Care
- Expanded partnerships of FQHCs and CMHCs to provide integrated care across the Four Quadrants
- Consideration of Mergers of FQHCs and CMHCs to provide integrated care for all populations
- Increased use of innovative technologies to improve care access and quality, cost effectiveness

Some Thoughts on What to Do First?

- To address the immediate budget crisis:
 - Medicaid Health Homes for Complex, Costly Patients
 - Project ECHO clinic for complex patients, chronic pain, opioid treatment
- Remove barriers to broader telehealth usage
- Move to alternative payment models to make strategies feasible
- Identify resources to support practice change facilitation
- Think about what models and practices fit into your local context and environment

What's next in West Virginia?

- Use the messages heard today to refine the strategies
- Present ideas and strategies to Steering Committee
- Examine Behavioral Health Integration Strategies in the context of the overall plan, including the shift to alternative payment methods
- Identify organizational and personnel resources to support necessary changes
- Develop detailed implementation plan with milestones, timelines, and budgets
- Get to work!

Thanks for your attention!

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Questions welcome!

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