



## Behavioral Health and Primary Care Integration Workgroup

*Friday, January 8, 2016, 9:00 a.m. – 11:00 a.m.*  
*West Virginia Department of Health and Human Resources*  
*One Davis Square, Suite 100 East, Conference Room 134*

### MEETING SUMMARY NOTES

#### Expected Results:

- Gain a better understanding of integrated care principles, models, and recommendations to strengthen primary care and behavioral health integration in West Virginia
- Through interactive dialogue and parallel thinking, provide feedback on strategies, solutions, and areas of concern
- Outline next steps and assignments
- Strengthen working relationships among key stakeholders

**Facilitator:** Becky King, Collective Impact

**Participants:** 42 people (Electronic participation was not available)

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
<b>Welcome, Introductions and Opening Remarks</b>	The second meeting of the SIM Behavioral Health and Primary Care Integration Workgroup opened with welcoming remarks by Joshua Austin, SIM Project Coordinator. Becky King, facilitator, reviewed the agenda and expected results, along with guidelines for participation. Garrett E. Moran, Ph.D., Project Director for The Academy for Integrating Behavioral Health and Primary Care, was introduced. Workgroup networking and introductions followed.

<p><b>Setting the Stage</b></p>	<p>Dr. Moran provided a recap of the initial workgroup meeting held on October 2, 2015. Participants heard a presentation on the integration of behavioral health and primary care and discussed strengths, barriers, and opportunities in West Virginia. Whitepapers from the West Virginia Primary Care Association and the West Virginia Behavioral Health Providers Association were provided to meeting participants prior to the October 2<sup>nd</sup> meeting. Key issues identified included:</p> <ul style="list-style-type: none"> <li>○ Difficulty recruiting and retaining providers, especially for children and youth</li> <li>○ Prior authorization requirements for behavioral health services</li> <li>○ Essential information sharing limits due to West Virginia privacy laws</li> <li>○ Historically weak working relationships among community mental health centers and federally qualified health centers</li> <li>○ Barriers to wider telehealth implementation</li> <li>○ Weak implementation of EHRs and the inability to share data and information</li> <li>○ Current professional training programs are not preparing people for integrated care</li> <li>○ Lack of SBIRT billing codes, behavioral health parity</li> <li>○ Need for better inter-professional, inter-organizational relationships with mutual respect and role appreciation</li> <li>○ Need for consistent and standard outcome and quality measures</li> <li>○ Need for clear care coordination models and payment</li> <li>○ Need for action and continued discussion</li> </ul> <p>Dr. Moran noted that various levels of integration and promising practices are underway in communities across West Virginia.</p>
<p><b>Behavioral Health and Primary Care Integration: Recommendations for Discussion</b></p>	<p>Dr. Moran continued his presentation and provided an overview of the current environment in West Virginia. Poor population health indicators; challenges with hiring and retaining providers; sustaining innovative grant-funded practices; and the burden of mental illness in terms of spending were highlighted as key issues affecting the state.</p> <p>Following a review of the Four Quadrant Clinical Integration Model, the principles of effective integrated behavioral health care were reviewed as follows:</p>

- Patient-centered team care/collaborative care
- Population-based care
- Measurement-based treatment to target
- Evidence-based care
- Accountable care

Following brief Q&A, Dr. Moran proposed recommendations to close the gap in West Virginia regarding the aforementioned areas. Recommendations are summarized and outlined.

- Address workforce shortages and maldistribution by broadening support and removing barriers to telehealth use.
- Utilize the Project ECHO model to make specialist expertise more broadly available.
- Utilize the Collaborative Care/Consulting Psychiatrist Model to improve treatment of common, less serious behavioral health disorders in primary care.
- Broaden the use of community health workers, health educators, peer coaches for SUD, and peer services for mental health, while also standardizing training and certification.
- Revise academic curricula for health professions to support team-based models of integration.
- Expand use of Medicaid Health Homes for the most complex and costly super-utilizers, with technical support from Project ECHO complex patient clinics
- Expand Level 3 PCMH Certification with support from the Collaborative Care/Consulting Psychiatrist Model.
- Expand cooperation and collaboration between CMHCs and FQHCs and explore the feasibility of merged models.
- Utilize more innovative technologies, applications and resources.

Dr. Moran prioritized the steps to take, as summarized and outlined above.

- To address the immediate budget crisis, focus on Medicaid Health Homes for complex, costly patients, and utilize Project ECHO clinics for complex patients, chronic pain, and opioid treatment.
- Remove barriers to broader telehealth usage.
- Move to alternative payment models to make strategies feasible and sustainable; none of these

	<p>changes can be sustained in a fee-for-services payment environment.</p> <ul style="list-style-type: none"> <li>○ Identify resources to support practice change facilitation.</li> <li>○ Think about models and practices that fit into local contexts and environments.</li> </ul>
<p><b>Large Group Discussion and Feedback</b></p>	<p>Following the presentation, participants provided both written and verbal feedback on the proposed concepts and recommendations using the <i>Six Thinking Hats</i> tool.</p> <p><i>These comments have been lightly edited for clarity, grammar and uniformity of spelling by SIM Project Coordinator Joshua Austin.</i></p> <p><b>1. Red hat (feelings, intuition): After hearing the presentation and proposed models and strategies, I feel...</b></p> <ul style="list-style-type: none"> <li>○ The presentation was excellent but must be modified in some areas due to community differences</li> <li>○ Collaborative Care Model has promise</li> <li>○ Incentivize CMHC-FQHC into one organizational model makes sense—Feds should encourage that</li> <li>○ Excited about the programs we have and are growing and their capacity to provide integrated services</li> <li>○ Anxious about quality-based reimbursement implementation, given some of the patients needs we have</li> <li>○ Motivated to get started</li> <li>○ Confused about approach for West Virginia</li> <li>○ We should move forward and stop talking</li> <li>○ Interested</li> <li>○ Skeptical</li> <li>○ Fear of unintended consequences</li> <li>○ Hopeful that we can improve health outcomes for West Virginia</li> <li>○ Is doable—should not just focus on FQHC—need primary care in behavioral health</li> <li>○ Changes can be made</li> <li>○ Somewhat overwhelming amount of change needs to take place and a little worried about financial resources available. How do we bridge gap until savings kick in?</li> <li>○ Doable—frustrating that we have not expanded</li> </ul>

- There is a significant need for CMHC-FQHC collaboration. I also feel concerned about the silos in place and protective nature. Small numbers are affecting the ability to move to accountable care.
- Motivated and driven—the task is a big one with significant financial implications to the State of West Virginia and the population health of West Virginians
- Good, all models seem to be diverse and are a sound fit for West Virginia
- Presentation was comprehensive
- Good opportunities for meaningful collaboration and team development ideas
- This represents a reasoned approach/pathway to change
- The West Virginia process/system must change/cannot be sustained
- Frustrating to not move forward. We should take the models that have been demonstrated already and proven to work and take them to scale (CHW care teams, dual eligibles, Project ECHO, telehealth)—we have pilots: build upon them!
- They are still focused on high-level need tertiary care—same info we have heard over and over—90% of all disease/illness due to stress
- Hopeful that our statewide landscape is evolving to support the collaboration essential to shared ventures with behavioral health – primary care integration
- We are on the right track but have a lot of work to do
- It is a complex problem—integrated care at its best is new relationships and new competencies, so what does it take to develop/strengthen then build relationships?
- Inspired and excited. Good information was presented. Eager to review Project ECHO and other programs/sources discussed and brainstorm how to use for pregnant women with substance abuse disorders.

**2. White hat (facts, information): Information that is missing and should be added...**

- Addressing funding transitions—how do we move from one payment to another?
- Business performance—what were the revenues/expenses of these models?
- Cost/effectiveness studies are a must
- Really does not address employed individuals and how commercial insurers will encourage integration
- I need to look more into the programs and models with our organization in mind

- Status on key players—specific directives of FQHCs and behavioral health centers
- Ideas about mergers or integration of FQHCs and CMHCs—where to start—how to break down barriers
- Understand that Cherokee Health System is unique because of leadership—not so much their system—West Virginia has so many proven integrated programs that are just not sold or marketed as well
- More detail on Project ECHO and Washington’s Collaborative Care models
- Step-by-step from a patient perspective
- Number served by CMHC
- Details on what organizations can partner together
- Costs
- Needs to be more West Virginia specific
- Need to go a little deeper around opportunities and barriers of telemedicine
- Agree that co-location is not collaboration
- Payment issues driving silos
- Who will drive the change process and who will provide details around process improvements (i.e., member identification, cost savings, successes, and initiatives)
- Cost effectiveness
- Business pro forma
- Additional West Virginia specific data—as detailed as possible—what \$ are spent, from what sources, for what services to what providers. And what are the outcomes. People need to see the “results” of the last 20 years
- We need to share better what has worked in pockets of the state and consistently document impact, data, and cost savings—we need financial models for possible replication of them
- If lowest level of care would be more available through mental health counselors, nurses, and social workers, laws must be updated instead of creating new para-professionals
- Examples: short-term, long-term costs—real (hard) and soft; lessons learned
- How to implement and get providers on board
- What is working and not working and why in West Virginia?
- Integrated EMR products
- Data extracts, analysis around target groups—baseline and goals

- Policy and regulatory barriers holding us back
- Organizational approaches such as staff engagement
- How to move from fee-for-service to value payments? Our payment system is currently preventing us from doing quality care, yet need the concrete steps to get from A to B.

**3. Green hat (creativity, possibilities): What we might do differently, or a new, innovative, or different approach to take is...**

- Allow for trials and models to test possibilities in different areas
- Intensive case management
- New utilization of swing beds in hospitals for crisis
- Stabilization of super-utilizers
- Congregate housing for super-utilizers
- Set up workgroups to set those tasks in motion
- Be open to piloting several different models, implement, and report back to the group
- Narrow focus or group – not everyone will buy in
- Staff training
- More loose interaction among providers to break down barriers
- Do not forget human touch in service provisions (e.g. caregivers)
- Focus early on super-utilizers
- We all have the same goal—work collaboratively
- Focus on conserving resources/building community
- Support tech acquisition and develop!
- Call line for mental health and substance abuse—updated directory of resources daily—expand to PCP?
- Project ECHO definitely seems plausible
- Applications that are available seem unique and interesting
- Support case management for dual eligibles
- Support case management in general
- Financially foster the care team collaborative model
- Focus on super-utilizers

- Coordinate group discussion of a regional FQHC and regional comprehensive mental health centers to determine state of current collaboration
- Try to start a West Virginia model and not implement another state's initial plan
- Having the current facilities share their model
- Capitalize on West Virginia's telehealth history and experiences—telehealth should be considered as an opportunity to improve physical and mental health. Ex. Project ECHO
- The key word is do. A lot of folks historically—not much action. Decide and do. Be willing to test, adjust (fail) and keep doing. Status quo is not an option.
- Expand care teams—CHWs; use telehealth; expand national models like Project ECHO; work on scope of practice issues
- Allow current holistic providers to be available at full educational level
- Specific to access issue raised: West Virginia has a new call line, 844-HELP4W, which is designed to address mental health and substance abuse access initially. This could easily be evolved to support primary care access and navigate, support, and help those needing care services connect with what they need, where they need it.
- Encourage development of an integrated approach through future providers at the educational level of their training with a certification across disciplines
- A West Virginia approval process for medical ROI to different providers could accept ROI's from one another to promote timely communication
- Consider using patient incentives for following treatment regimen(s)

**4. Black hat (caution, negatives): In my opinion, the biggest downside or area of caution is...**

- Too many turf issues—group did not recognize problem—group felt invited to
- Additional resources
- Not aligning programs with financial underpinnings of health care delivery
- The measures for outcomes remain sticking point. Sensitivity to change, observer bias, etc.
- The anxiety and confusion for patients and providers during changes
- Unwillingness to change
- Want to protect own organization and efforts
- Transition to value-based

- Politics/turf
- Payment systems, i.e. uncertainty
- Conservative nature of organizations
- Reluctance to change
- Loss of identity when mergers occur—which mission wins?
- Resistance to change
- Technology silos infrastructure—technology availability
- Attitudes—need to change—stigma related to CMHC
- Use of data is not one-size fits all
- System support regulation/barriers
- Patient participation—continue in established programming
- Funding is a worry item—how to bridge fiscal gap before savings kick in
- Not biggest issue but need to suggest language change away from use of mid-level provider
- Historic “siloes” delivery of care
- Infrastructures that are in place
- Broadband limitations for telehealth opportunities
- Lack of EHR data integration
- Members have to give permission to discuss behavioral health issues with the PCP
- Funding is always a downside
- Parochial attitudes and willingness to maintain status quo—little evidence that substantive change has occurred over the years despite a lot of talk/attention. Do not initiate if you are not willing/ready to finish.
- We need to expand broadband. One model will not work. Let’s start with low hanging fruit/most promising/least costly.
- M.D.s, i.e. psychiatrists, still want control via telehealth system
- Pace—too fast, too slow
- No mechanism to pay for broadband—limitations paying for EHR—need examples
- Limited providers to complete services
- Broadband not always available where we need it the most
- “Regression to the mean” with primary care/behavioral health mergers
- Do not lose sight of those with serious mental illnesses and the culture of “cannot mingle” primary

care/behavioral health care

- Need system support and buy-in at the top to address silos
- Investment of EMR and \$ expensive technology infrastructure

**5. Yellow hat (positives, benefits): The recommended strategies could work because....**

- Good model
- Improves access, reduces disability and increases quality of life
- Team-based care is positive
- Those present seem open to change
- Value-based payments are coming
- Skilled group of providers with much interest in making this work
- Expansion of telehealth
- Tracking of outcomes
- Integration is necessary
- Stakeholder involvement
- Technology seems to be increasing
- Team based care is a positive, comprehensive, forward-thinking, inclusive
- We have a broad health care population coverage
- West Virginia budget initiatives must result in financial savings for the state and for members
- Everyone will benefit as long as collaboration stays positive
- They work in other markets—it is not rocket science—it can work in a West Virginia environment
- We already have pilots—select 2 or 3 good ones; we have payors who are innovative, and we have lots of room to improve population health
- Better than what is happening now—still just shuffling deck chairs on the Titanic
- It is not a one-size fits all; there is something for everyone to consider, a pathway. The key is contemplating risk wisely and not allowing it to immobilize efforts.
- We have had some providers make it work
- The possibility of better aligning services since West Virginia is a small state
- Good job of “planning the plan” and how we will get there
- Look at changing 1-2 simple policy regulations to move telehealth capabilities and fixes forward

**6. Blue hat (purpose, manage): Suggested next steps...**

- Identify the successful models/narrow our focus
- Form workgroups on each recommendation
- Move to implement
- Start with small group/part of state
- Pick one thing and go forward quickly
- Please share attendance list and contact information
- Start to establish workgroups on key areas, ex. broadband access, changing privacy laws
- Identify top individuals to focus on excessive costly health care
- Determine what is already successful, so we build on those initiatives and then create next steps
- Collaborative meetings of FQHCs, CMHCs, and Medicaid MCO partners
- Everyone should start by picking certain models to start and not all models together
- Pick a project and go forward. Move with those that are ready/willing to move. Share results, both positive and negative
- Include/inform/educate and challenge communities not moving
- Align/coordinate work of payors—where and how resources will be directed, outcomes expected and results required
- Select a population, such as upper-utilizers or dual eligibles
- Select a model or tool that has been demonstrated and roll it out
- Make sure behavioral health and primary care are integrated into care teams
- Do not give up on PCMHs; they take time
- Allow all current professionals to work at a capacity relevant to training and pay them  
\*West Virginia needs a sea change: majority of this population is discouraged, depressed, disillusioned, desperate, drugged, dying, and more psychological/medical approach will not touch this. We need person vs. illness approaches.
- Integrate motivational interviewing into all professional training/education
- Integrate life skills into all primary education systems K-12 and up
- Solicit initiatives being pursued/contemplated and use them to evolve interest and learning; offer support, guidance, resources as incentives to “get started” to act
- Identify resources at today’s meeting and make available

	<ul style="list-style-type: none"> <li>○ Identify the top 5 barriers and key members and others who can work on each with timely solutions—keep workgroup updated</li> <li>○ Select a model and implement</li> <li>○ Ask people to state their names before they speak so we get to know who they are—I’m a newbie ☺</li> </ul>
<b>Next Steps</b>	<p>In addition to the <a href="#">blue hat</a> suggested steps identified by participants, next steps outlined as part of Dr. Moran’s presentation were reviewed as follows.</p> <ul style="list-style-type: none"> <li>○ Messages heard today will be used to refine strategies. Members of the SIM Project Management Team will follow-up with participants interested in discussing their feedback in more detail.</li> <li>○ Ideas and strategies will be presented to the SIM Task Force in some capacity.</li> <li>○ There will be an examination of behavioral health integration strategies in the context of the overall SIM Health System Innovation Plan, including the shift to alternative payment methods.</li> <li>○ We must Identify organizational and personnel resources to support necessary changes.</li> <li>○ We must develop a detailed implementation plan with milestones, timelines and budgets.</li> </ul>

**Group Checkout** – *Responses lightly edited for grammar and spelling*

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> <li>● Dr. Moran’s presentation was very comprehensive and did not show bias towards a particular approach</li> <li>● Focused</li> <li>● 2 minutes of networking</li> <li>● Liked the large group discussion and ideas</li> <li>● Liked large group conversation over small groups much better. Better discussion.</li> <li>● Good overall start to discussion</li> <li>● Great meeting—very informative</li> <li>● Exciting possibilities</li> <li>● Good collaborative discussion</li> </ul>	<ul style="list-style-type: none"> <li>● Would have liked the time to be expanded to allow Dr. Moran to go through each of his slides with his opinion and discussion.</li> <li>● Great stuff!</li> <li>● Would like more time</li> <li>● Need larger room for everyone to be at the table</li> <li>● Recycling some information all over again with no decision/action</li> <li>● Need a longer block of time to spend time on more discussion</li> <li>● Bigger space</li> <li>● Real world schedule of milestones/deadlines is needed to</li> </ul>

<ul style="list-style-type: none"> <li>• Great on time!</li> <li>• Hat strategy was effective</li> <li>• Tight time frame forced a “focus”—got more results</li> <li>• Well structured and organized</li> <li>• Clear goals</li> <li>• Nice presentation</li> <li>• Adherence to time</li> <li>• Timely—thank you!</li> <li>• Well organized</li> <li>• Good facilitated discussion to draw out broad output</li> <li>• Ran on time</li> <li>• Great blend of people/interest groups</li> <li>• Great meeting</li> <li>• Much more productive due to Becky’s facilitation</li> <li>• Staying on time—focus on topic!</li> <li>• Worked well</li> <li>• Excellent presentation</li> </ul>	<p>push planning to a conclusion</p> <ul style="list-style-type: none"> <li>• More time on second half of presentation</li> <li>• Nobody from State Medical/State Hospital Association—should invite (<b>Editor’s note: We did. Nobody accepted the invitation.</b>)</li> <li>• Lecture was too long</li> <li>• Starting to think about what this looks like from bottom up—patient/provider experience</li> <li>• Looking at where we are and what needs to be next steps</li> <li>• Though it may take more time, small breakout groups are more beneficial</li> <li>• Examine specific successes and ongoing efforts in West Virginia</li> <li>• Help facilitate piloting of some of these models discussed</li> <li>• Every meeting should have a visual on where this meeting/group fits in the big picture. All these workgroups, committees, etc. are difficult to conceptualize and understand when all we’re doing is attending many meetings. How do we all relate?</li> <li>• Need better room for larger group</li> <li>• Have people state name/organization before they speak. Let’s start to take some action—need some workgroups!</li> <li>• Eliminate parts of presentation—target population knows prevalence of illness/importance in health care</li> <li>• Too many disguised turf comments</li> </ul>
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**Additional comments:**

- I am not sure I really know next steps on state’s recommendation on action items.
- Begin shared data analysis among all stakeholders to identify target groups that will allow baseline and goal setting.

- We need to have a model. 2. We need to get the providers on board. 3. We need to do community marketing to reach the ones that are currently not seeking treatment. 4. Education to members.
- There are several good models of integration of behavioral health and obstetrical services in West Virginia to address pregnant women with substance use disorders. They have a big impact because improved care of women, babies and families. These programs are limited—only in a few sites and most are barely sustainable with current federal funds and other payment/grant constraints. How to move forward: both to expand them statewide and sustain them. Data is very difficult to obtain. Program evaluations are difficult to do.
- To facilitate stakeholder thinking on behavioral health and primary care integration it might be helpful if there was an interactive presentation on what West Virginia collaborative approaches are in place/working toward integration, such as Partners In Health Network and any others in the works. Cabin Creek Health System: some will already be aware of these, many are not. It would help people conceptualize possibilities and think out models together.

**Summary Notes Submitted by: Becky King, January 11, 2016**

**Summary Notes Revised by: Joshua Austin, February 3, 2016**