All Hands on Deck: Best Practice Strategies in Integrated Care

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

HMA
Health Management Associates

Agenda

- Overview of Colorado's Framework for BH Integration
- Common evidence-based components of Integrated Care Models
- Benefits and Challenges of Integrated Care
- Role Waiver Elimination Act can play in primary care and integrated care MAT services and supports.
- Frameworks for implementing integrated care that fits the needs of the clinic and community
- Clinical, Operational, Financial, and Training/Education Infrastructure and champions needed to successfully implement integrated care

What You Will Learn Today

At the conclusion of this training, participants will be able to

1. Differentiate the more commonly known integrated care models available in primary care settings and in behavioral health entities.
2. Explain how integrated care results in improved outcomes, lower costs, greater accessibility, and improved workforce retention and satisfaction.
3. Understand the components of medically assisted treatments and innovative integrated care strategies for incorporating it into primary care settings.
4. Describe where they are at currently according to established frameworks of integrated behavioral health care.
5. Identify potential clinical, operational, financial, and training strategies for implementing and sustaining integrated care models and practices.

What is Integrated Care?

There are many terms used to describe integrated care:

- Integrated behavioral health care
- Integrated care
- Collaborative Care
- Co-located Care
- Coordinated Care
- Primary Care Behavioral Health
- Reverse or bidirectional integrated care
- Interprofessional health care

Can you think of others?

Photo: google image posted by actors.

How Are We Defining Integrated Care in This Training?

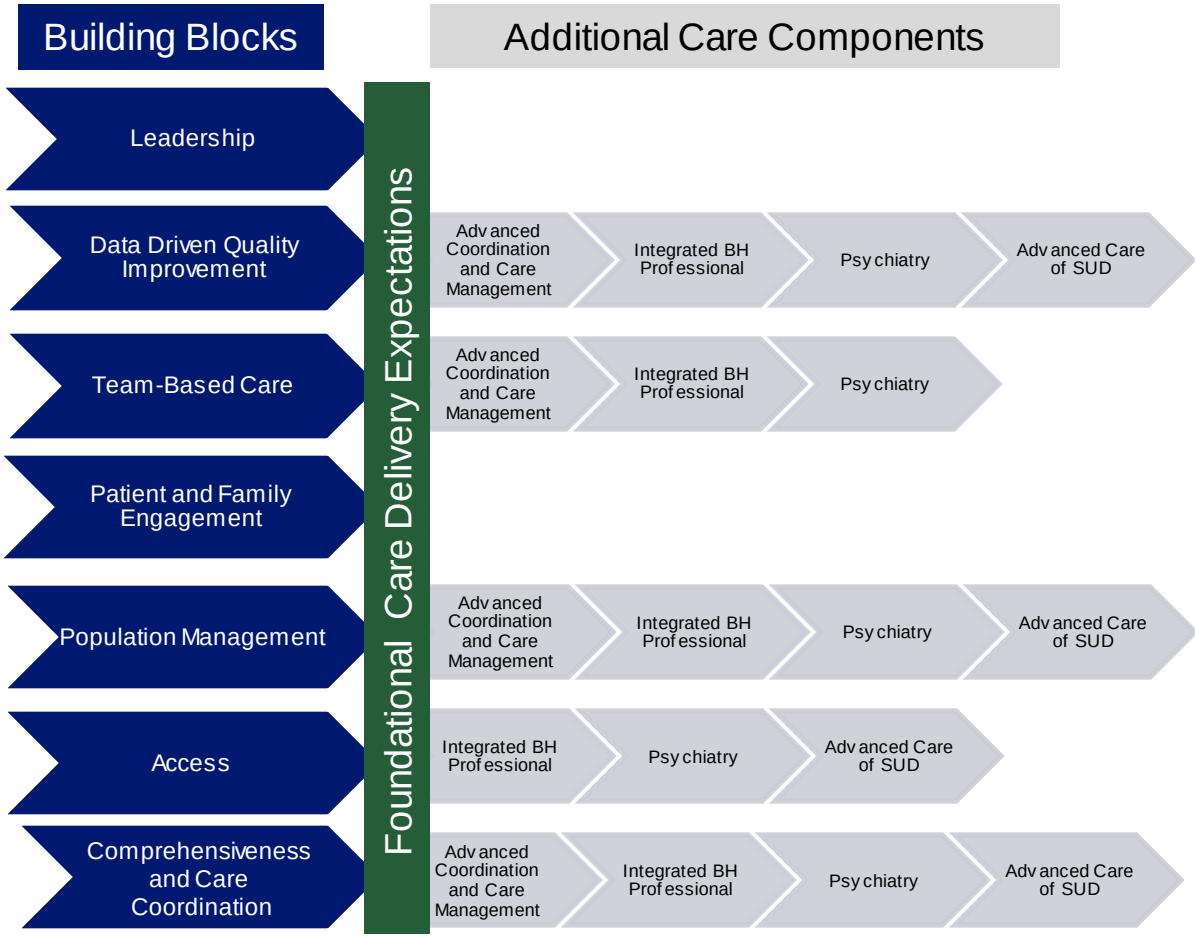
The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use 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 care can also take a prevention approach, utilizing tools to identify needs early on and address those needs using health promotion strategies. The physical and behavioral health services occur in the same care setting to the extent possible.

Colorado HB22-1302

Colorado's Framework to Behavioral Health Integration

- In June 2022, a team of integrated care experts in Colorado developed Colorado's "Building Blocks of Behavioral Health Integration" to guide the advancement of integrated care in the state.
- Around the same time, national frameworks of behavioral health integration were forming to help construct a glidepath to advancing this level of care.
- Building on Colorado's behavioral health integration building blocks, this training will illustrate how national frameworks developed from evidence-based components can support Colorado providers in advancing integration.

Building Blocks and Components of Colorado's Behavioral Health Integration Framework



Note: **Foundational Care Delivery Expectations** are recommended requirements, but practices may choose any combination of additional care components to implement.

Important to Note

As endorsed in Colorado's "Building Blocks of Behavioral Health Integration" report,

- Practices have the flexibility to choose their approach to behavioral health integration across primary and specialty care, as well as bi-directional settings.
- There is not one model of integrated care that is the goal. The needs and resources of a practice and community will drive this decision.
- The framework for behavioral health integration is not designed for a specific behavioral health diagnosis, or level of severity, but rather for the advancement of behavioral health in general of all Coloradans in a primary care setting.
- Foundational components expressed through this training are to support the work of practitioners in primary care settings who are taking initial or expanded steps toward improving behavioral health integration services for its patients.

Evidence Based Components of an Effective Integrated Care Model (1)

Team-Based Approaches and Cross Training

- Who is on the team?
- What cross training will help with clear communication and roles?
- When will the team meet?
- What criteria will be set for measuring team-based care outcomes?

Screening

- What systematic screening of patients will occur?
- Who will conduct and review the screening?
- What workflows will be developed as a result?

Evidence Based Components of an Effective Integrated Care Model (2)

Change Management and Provider Readiness

- How well is the system prepared for change?
- What is being included in the "system?"
- Who or what is ensuring providers are ready?

Brief Interventions

- What brief education and BH/SUD interventions will be implemented?
- Who will be providing these interventions?

Evidence Based Components of an Effective Integrated Care Model (3)

Clinical Registries

- What formal or informal methods will be used to track patients and patient referrals?
- Will the registry be integrated into the EHR?
- Will the registry include severity measurement, attendance, care management interventions, and any medical measures?

Proactive Care Coordination and Follow-up

- What will the follow-up protocol with patients be and by whom?
- How will care coordination work in partnership with the registry, BH activation, and assertive outreach?

Evidence Based Components of an Effective Integrated Care Model (4)

Care Management

- What patients will receive care management?
- How will care management services be provided and by whom?

Measurement Based Care

- How are you tracking treatment progress and how is it informing clinical decision-making?
- What routine assessment will you use to track patient progress?

Evidence Based Components of an Effective Integrated Care Model (5)

Quality Improvement

- What population-level performance metrics would you like to monitor around BH and PH integration?
- Who is on your quality improvement team and how will they help monitor integrated care?

Patient Education

- What patient education materials/ workbooks (with cultural considerations), are available for self-management coaching and activity guidance?
- What would systematic education and self-management goal-setting look like in your setting?
- Where and how would patient education be tracked?

Evidence Based Components of an Effective Integrated Care Model (6)

Personalized Care Planning

- How do we actively engage our patients in their decision-making and goal setting?
- In what ways do we identify and track health related social needs in the context of care planning?

Engagement and Empowerment

- What does engaging and empowering of patients, their families, and team-members look like in our day-to-day interactions?
- How do we track and achieve early initiation of follow-up and patient engagement?

Evidence Based Components of an Effective Integrated Care Model (7)

Multidisciplinary Care Teams

- How do we identify who is on the care team?
- What role does the patient and their family play on the care team?
- What changes in workflow are needed to allow for increased contact?

Sharing of Treatment Information

- How do we communicate and collaborate with one another informally and formally to share care information?
- What methods do we use to share health information electronically, ethically, and securely?

Evidence Based Components of an Effective Integrated Care Model (8)

Tracking of Referrals and Coordination

- Whose responsibility is it to track referrals?
- What is the follow-up processes to ensure successful and timely referrals?
- How are patients identified prior to or during a visit for referral and care coord?

Connections to Community and Social Services

- How are we staying current with our community resources?
- How are our patients linked to community organizations/resources?
- Do we make formal arrangements and have processes in place to track for consistent follow-up?

Practice Case

You work in a rural clinic serving a large majority of refugee families and individuals with significant health related social needs. You are looking to grow your integration of behavioral health services and supports. Currently, you have one social worker who helps with patients who are in need of urgent or emergent resources. She stays pretty busy also helping patients to enroll in Medicaid and SNAP. She is also finding a lot of her patients have significant behavioral health needs, especially more pronounced since the pandemic. The administration and providers agree that more needs to be done to support their patients' comprehensive health needs.

- What could the system do to identify patients with behavioral health needs?
- What additional team members would be important to engage in the workflow?
- How would you recommend modifying documentation and referral strategies and/or networks to ensure patients are aligned with the right care and follow-up services?

Benefits of Integrated Care

- Reduce Costs
- Reduce Disparities
- Improve Outcomes
- Improve Provider Well-Being
- Expand the Workforce
- Improve Access to Care

Challenges to Integrated Care

- Workforce shortages
- Confusion around BH licensure, qualifications, and billing
- Inattention to clinical, operational, financial, & training implications
- Building effective cross discipline teams
- Lack of Attention to Change Management
- Communication and siloed data/reporting/documentation
- Funding

How are Medically Assisted Treatments being integrated into primary care services?

What is the Waiver Elimination (MAT Act) and how does it impact primary care?

- All providers who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for opioid use disorder in their practice if permitted by applicable state law.
- According to the Colorado Medical Society, effective on **June 27,2023**, all new license applications, as well as license renewals are required to complete a one-time Substance Use Disorder (SUD) education requirement for DEA prescribers under Section 1263 of the CAA 2023. The one-time SUD education requirement becomes a condition on a controlled medication prescriber's DEA registration beginning with the first applicable registration.

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Do I still need to apply for a waiver?

Providers seeking to prescribe buprenorphine for the treatment of opioid use disorder no longer need to apply for, or possess, a DATA-Waiver prior to prescribing the medication.

What am I now required to do?

Starting June 27, 2023, upon submission of your application, you will have to do at least one of the following:

- A total of eight hours of training from certain organizations on opioid or other substance use disorders for practitioners renewing or newly applying for a registration from the DEA to prescribe any Schedule II-V controlled medications;
- Board certification in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, American Board of Addiction Medicine, or the American Osteopathic Association; or
- Graduation within five years and status in good standing from medical, advanced practice nursing, or physician assistant school in the United States that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours.

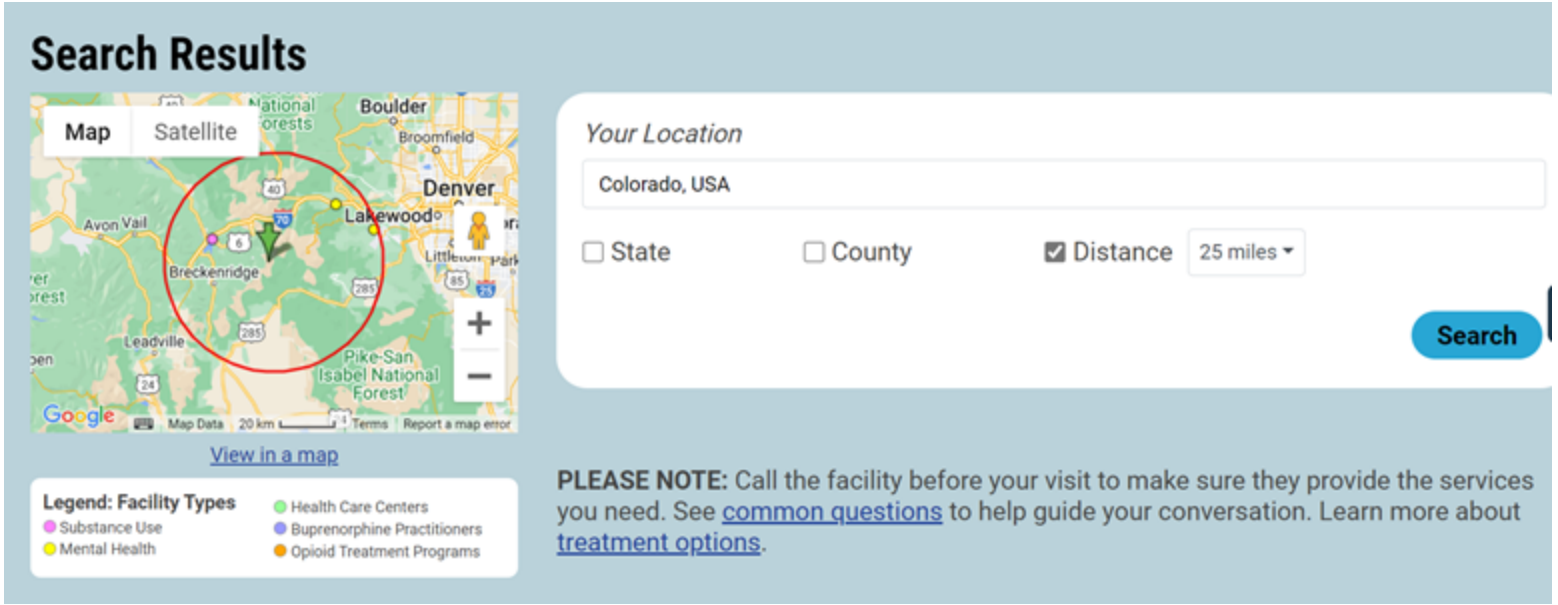
Where can I get more information?

[HRSA National Health Services Corp:]

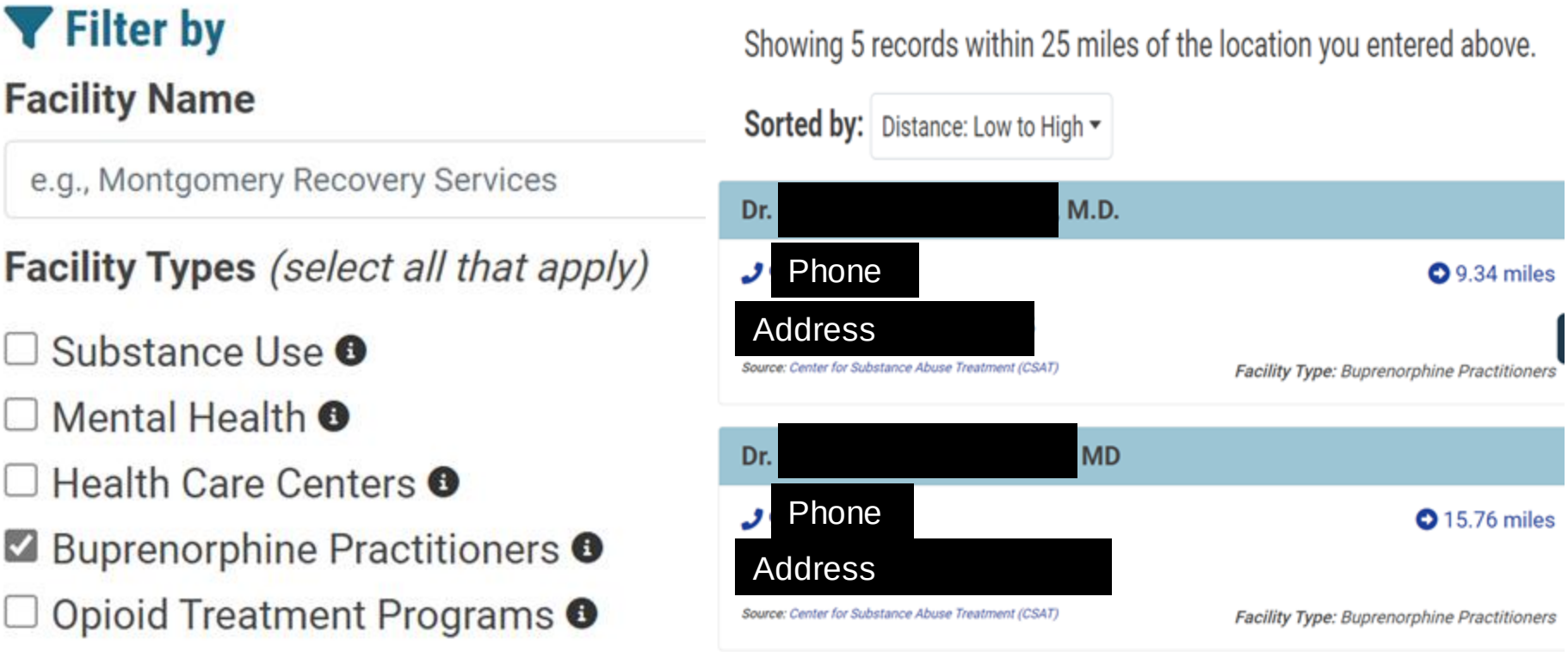
- Provides information, resources, and eligibility criteria to obtain free training to provide medications for opioid use disorder (MOUD) for eligible clinicians working to address the opioid epidemic.

Who is Providing MAT in your Area?

SAMHSA's FindTreatment.gov Directory of providers across the U.S. specializing in the treatment of substance use disorder (SUD) and mental illness.



SAMHSA's FindTreatment.Gov



Okay, so I want to take this step toward initiating or expanding integrated care in my setting. What do I do first?

Designing the best integrated care approach for your setting

Two established integrated care frameworks:

Montefiore Continuum-Based Framework

- Chung et al. (2016)
- Provides a series of steps that providers can take to move toward integration of behavioral health services into their primary care practices.

Comprehensive Healthcare Integration (CHI) Framework

- National Council for Mental Wellbeing (2022)
- An 8-domain framework for guiding implementation of integration of physical health (PH) and behavioral health (BH) (mental health and substance use conditions), that can help providers, payers and population managers to measure progress in organizing delivery of integrated services and demonstrate the value for sustainable integration. Inclusive of attention to social determinants of health and health equity for underserved populations.

Montefiore Framework: How it is Used

- Guides champions for integrated care in a series of incremental steps toward building the infrastructure that primary care practices can take to onboard advanced integrated care models.
- Inclusive of the needs and resource restrictions of smaller and medium-sized primary care practices.

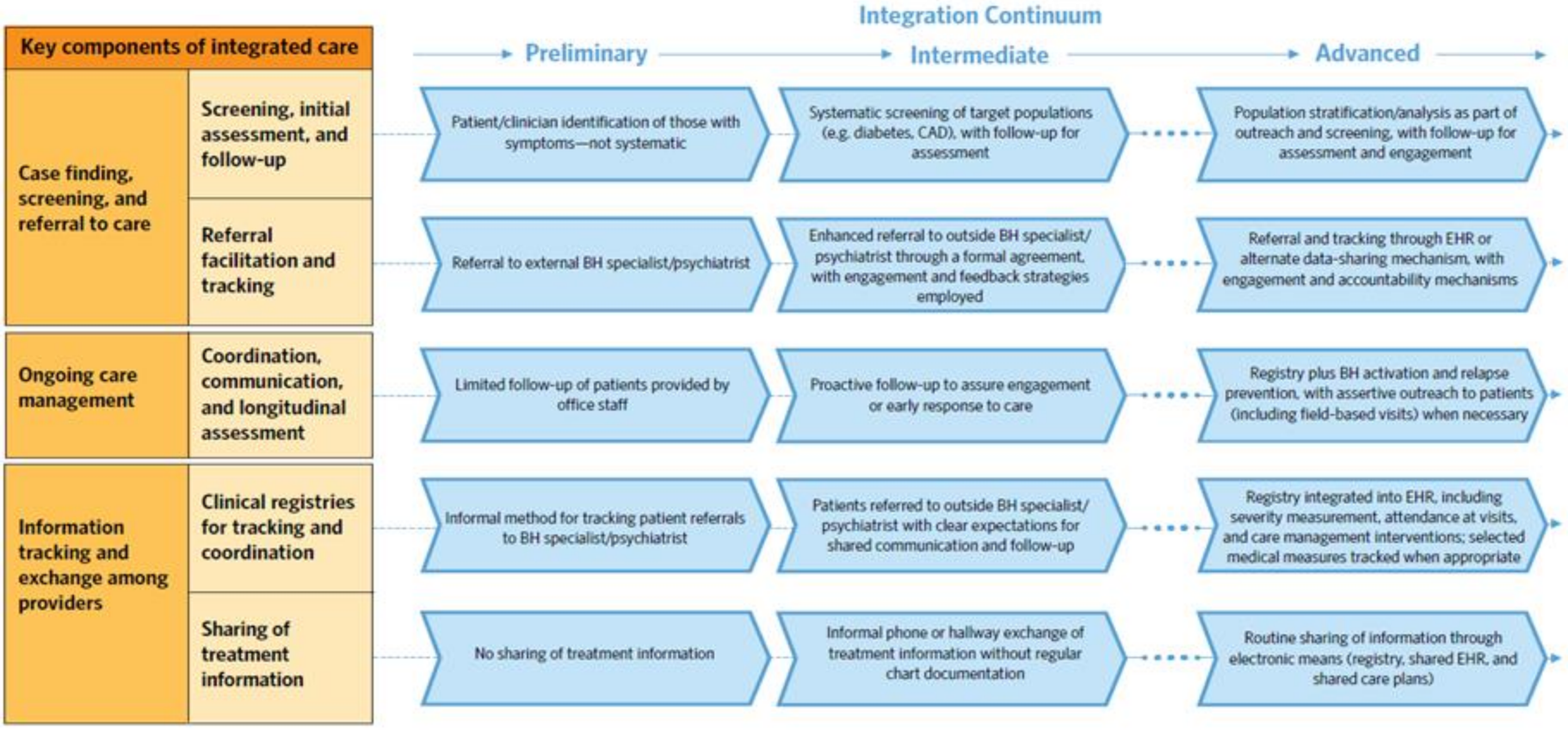
Montefiore Startup Checklist

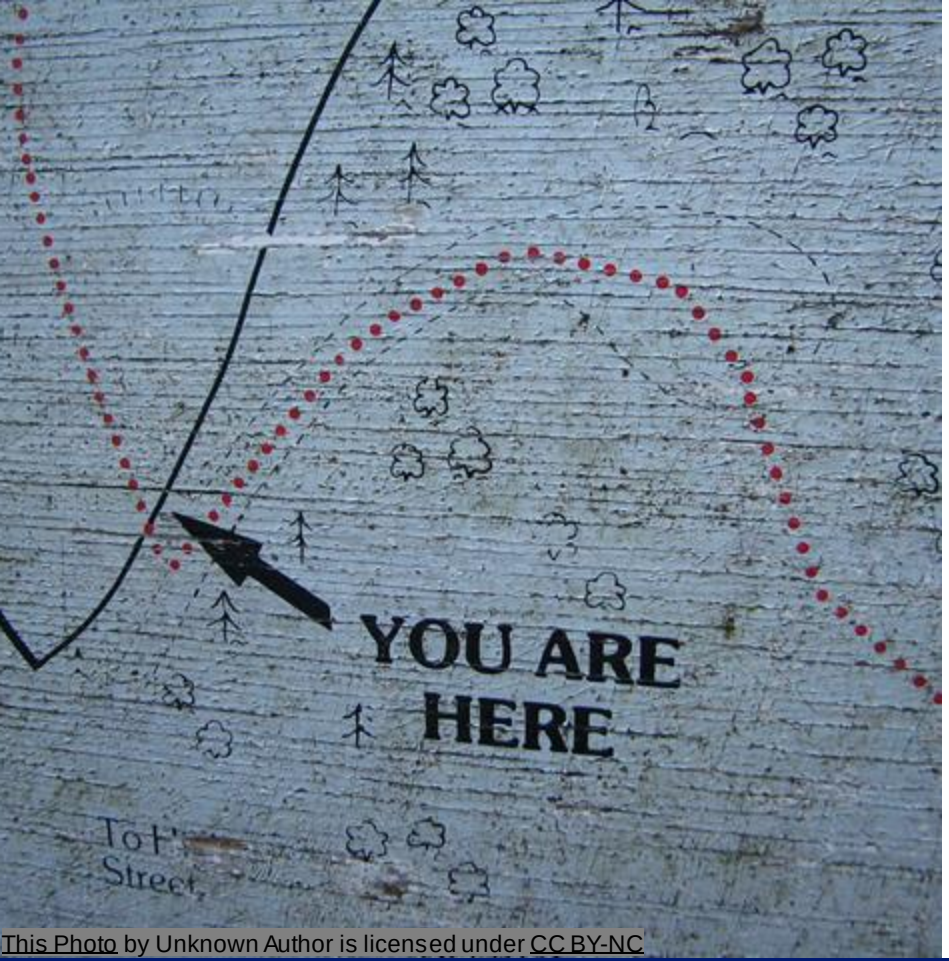
- [x] Obtain Leadership Commitment and Practice Champions
- [x] Assemble team to assess current landscape
- [x] Perform Self-Assessment
- [x] Perform Environmental Scan
- [x] Prioritize Domains for Change
- [x] Set specific, measurable, and achievable 3- to 12-month goals for each component
- [x] Assess existing and necessary resources
- [x] Assess attainability of goals

Montefiore 8 Framework Domains and Core Components

- Case finding, screening, and referral to care
- Use of a multi-disciplinary professional team—including patients—to provide care
- Ongoing care management
- Systematic quality improvement
- Decision support for measurement-based, stepped care
- Culturally adapted self-management support
- Information tracking and exchange among providers
- Linkages with community/social services

Partial Representation of Montefiore's Structural Framework



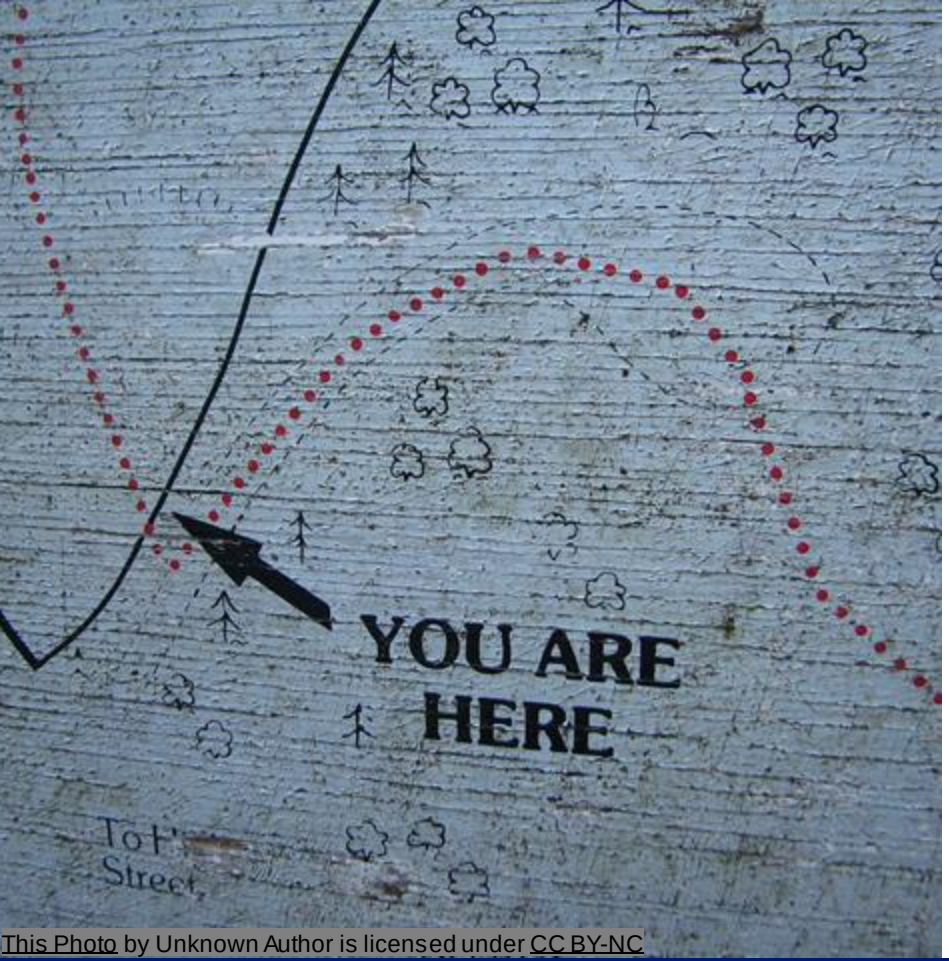


Where are You?

Based on the Montefiore condensed framework, where do you think your practice is located currently on each domain?

Where are You? – Montefiore Condensed Framework

- Obtain Leadership Commitment and Practice Champions
- Assemble team to assess current landscape
- Perform Self-Assessment
- Perform Environmental Scan
- Prioritize Domains for Change
- Set specific, measurable, and achievable 3- to 12-month goals for each component
- Assess existing and necessary resources
- Assess attainability of goals



Where are You?

Where on the Montefiore readiness checklist would you see your first or next step being in integrated care implementation?

Where are You? – Montefiore Readiness Checklist

Case finding, screening, and referral to care	Use of a multi-disciplinary professional team—including patients—to provide care	Ongoing care management	Systematic quality improvement
Decision support for measurement-based, stepped care	Culturally adapted self-management support	Information tracking and exchange among providers	Linkages with community/social services

National Council for Mental Wellbeing's Comprehensive Healthcare Integration (CHI) Framework (2022) 8 Domains and Subdomains

Domain 1: Screening, referral to care and Follow-up

- Screening and Follow-up
- Facilitation of Referrals

Domain 2: Prevention and treatment of common conditions

- Use of screening and prevention guidelines protocols
- Use of treatment guidelines or protocols
- Use of medication for common PH and/or BH condition

Domain 3: Continuing care management

- Longitudinal clinical monitoring and engagement

Domain 4: Self-management support

- Use of tools to promote patient activation and recovery

National Council for Mental Wellbeing's Comprehensive Healthcare Integration (CHI) Framework (2022) 8 Domains and Subdomains (cont.)

Domain 5: Multi-disciplinary teamwork

- Care team
- Sharing of treatment information, case review, care plans and feedback
- Integrated care team trainings

Domain 6: Systematic measurement and quality improvement

- Use of quality metrics for physical health program improvement and/or external reporting

Domain 7: Linkages with community/social services for social determinants of health

- Linkages to housing, entitlement and other social support system

Domain 8: Financial Sustainability Self-management support

- Process for billing and outcome reporting
- Process for expanding regulatory and/or licensure opportunities

What is the Anchoring Emphasis for the CHI Framework?

Emphasis is on co-occurring PH in BH settings and vice versa. Prioritized issues will vary based on age and other population variables

Figure A: The CHI Framework tool Domain 1 – Integrated Screening, Referral to Care and Follow-up and the First of Two subDomains: Screening and Follow-up for Co-occurring Conditions.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE	SCREENING AND ENHANCED REFERRAL	CARE MANAGEMENT AND CONSULTATION	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT
1. Integrated Screening, referral to care and follow-up (f/u).	**1.1** Screening and follow-up for co-occurring behavioral health (Mental health, SUD, nicotine), PH conditions and preventive risk factors. **1.2** Facilitation of referrals and f/u.	Response to patient self-report of co-occurring behavioral health and/or PH and/or chronic illness with f/u only when prompted. Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.	Systematic screening for high prevalence BH and/or PH conditions and risk factors3 and proactive health/BH education to support motivation to address risk factors and positive screenings. Includes patient engagement in these processes. Identify PCP and BH provider (if any) for all. Formal agreement between PH practice and BH providers to routinely facilitate referrals and share information about progress. Measurement of referrals to assess show rate and information exchange with the referral source.	Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services. Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team, or a BHC for a primary care team, to ensure follow up and coordination re positive screenings, with access to well-coordinated referrals to internal or external PH and/or BH service providers.	Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and more comprehensive analysis of whole patient population to stratify by severity of PH/BH complexity and/or utilization to match to level of intensity of integrated care coordination needed. In addition to integrated teamwork, there is a systemic collaborative and consulting partnership with PH and BH services in one or more locations that can help meet population needs internally through both integrated service delivery and enhanced referral facilitation to both internal and external partners, with automated data sharing and accountability for engagement.

Example

According to the CHI Framework…

- Which domain would you identify are your strongest and areas for growth?
  - Screening, referral to care, follow-up
  - Prevention and treatment of common conditions
  - Continuing care management
  - Self-management support
  - Multi-disciplinary teamwork
  - Systematic measurement and quality improvement
  - Linkages with community/social services for social determinants of health
  - Financial Sustainability

The Way to Integrated Care Is a Full System Enterprise

Clinical

What do we do for our patients?

Operational

How do we do it and support it?

Financial

How are the models used sustainable?

Training/Education- How do we retain fidelity and support/offer continuing education?

Peek (2008)

Examples of Clinical World

- Behavioral Health, Substance Use, and Health Related Social Needs Screening
- Evidence Based and Culturally Responsive Practices
- Offering of Care Continuum
- Patient and Family Engagement Strategies
- Stepped-Care
- Treat to Target
- Team-Based Care

Examples of Operational World

- Electronic Health Records
- Workflows
- Policies and Procedures
- Front and Back Staffing
- Space Allocations
- Scheduling
- Behavioral Health Registries
- Behavioral Health Team Members, Roles, and Supervision Structure
- Administrative Support and Resource allocations

Examples of Financial World

- Billing and Coding
- Return on Investment
- Start up and Sustainability Costs
- Proforma
- Performance Metrics/Measures
- Payor incentives
- Alternative Payment Models

Examples of Training/Education

- Onboarding
- Multidisciplinary shadowing
- Continuing Education
- Fidelity Measures and Reports
- Supervision

Practice Case Revisited

Your rural clinic that is serving a large majority of refugee families and individuals with significant health related social needs has decided start screening patients for their BH needs. The clinic's administration team assigned their only BH provider to design and develop the integrated care model. The BH provider presented to the medical director a strategy for screening patients during the vitals so the provider is aware if their patient has a behavioral health issue. They recommend the PHQ-9, GAD-7, ACES, and AUDIT as screeners to implement because they are most widely represented in the literature. All medical assistants who conduct patient vitals at triage were introduced to the screeners at a staff meeting and the BH provider explained how to use the tools. Three weeks later, very few screeners were being completed.

Q1: Based on what we have discussed in this training, what do you think is contributing to the lack of uptake with the new screening protocol?

Q2: What recommendations do you have for the behavioral health provider based on the 4 worlds previously introduced?

What Does This All Mean for Colorado and Growing Integrated Care?

- The ultimate key is making integrated care sustainable financially
- Colorado (via 1302) is working on a pathway for sustaining integrated care financially and growing the workforce to deliver services.
- Check out these presentations for more information (Visit the HCPF Safety Net Provider Landing Page **HERE**):
  - We Can't Do it Alone and We Don't Have To: Advancing Mental Wellbeing and Connecting Communities to Care with Behavioral Health Workforce Extenders
  - Behavioral Health Workforce: Meeting Today's Needs and Building the Pipeline for the Future

To better inform our future trainings and request topics for office hours, please complete this short survey. Use the QR code or short URL to access it. Your feedback is important. Thank you!

https://bit.ly/bhprovidertrainingsurvey

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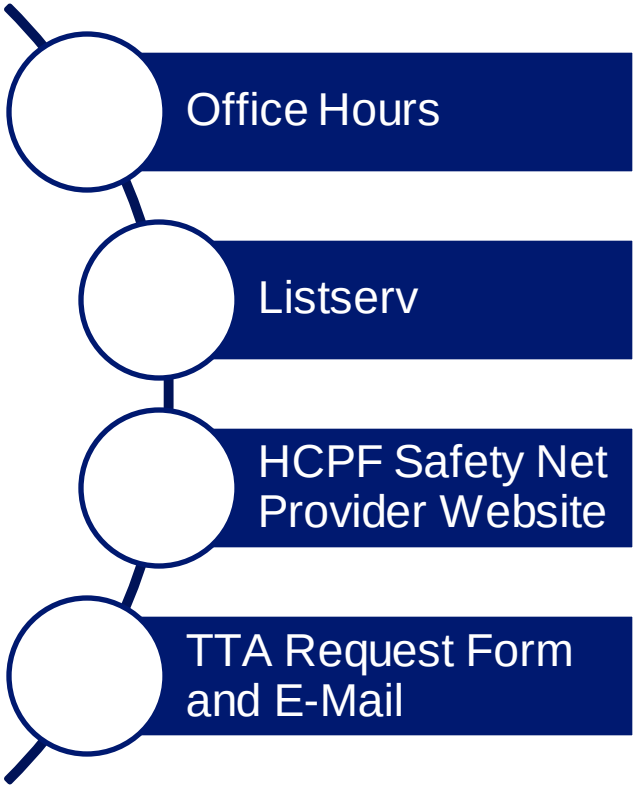
Appendix A: Additional Resources



Last Friday of the month @ 12pm MST, you must register
May Office Hours- May 31 @ noon, Register Here
June Office Hours- June 28 @ noon, Register Here

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

Visit the website for details on upcoming training topics and announcements, training recordings and presentation decks, FAQs and more: https://hcpf.colorado.gov/safetynetproviders

Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

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