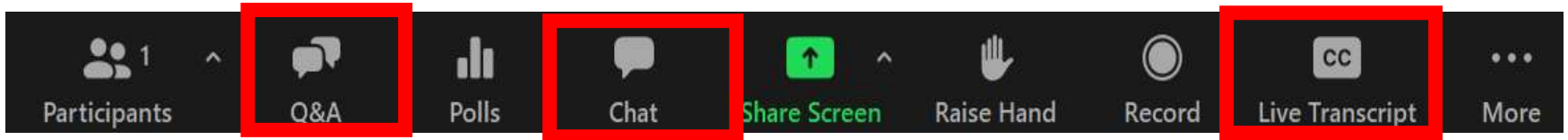
Comprehensive Health Integration Part 1: Introducing a New Framework

Wednesday, April 27th
12-1pm EST

Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**



Type in a **question in the Q&A box**

Click **Live Transcript** and then select **"Show Subtitle"**

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Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

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Poll #2: What best describes your organization? (check all that apply)

- Primary Care Provider
- Mental Health Provider
- Substance Use Treatment Provider
- Other (specify in chat box)

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Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)

Today's Presenters

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Medical Director,
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Professor of Psychiatry & Behavioral Sciences, Albert Einstein College of Medicine, *Member, Medical Directors' Institute*, National Council for Mental Wellbeing

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Owner, Collaborative Care Consulting*, Medical Directors' Institute*, National Council for Mental Wellbeing

Learning Objectives

- Identify domains of integration applicable to both primary care and behavioral health care.
- Discuss how to use the integration framework to assess the "integratedness" of a particular program.
- Categorize which integration construct is currently the closest fit for their organization.
- List at least three performance measures specific to integration operational and visible within your organization.
- Identify at least one new payment methodology to support integration within your organization.

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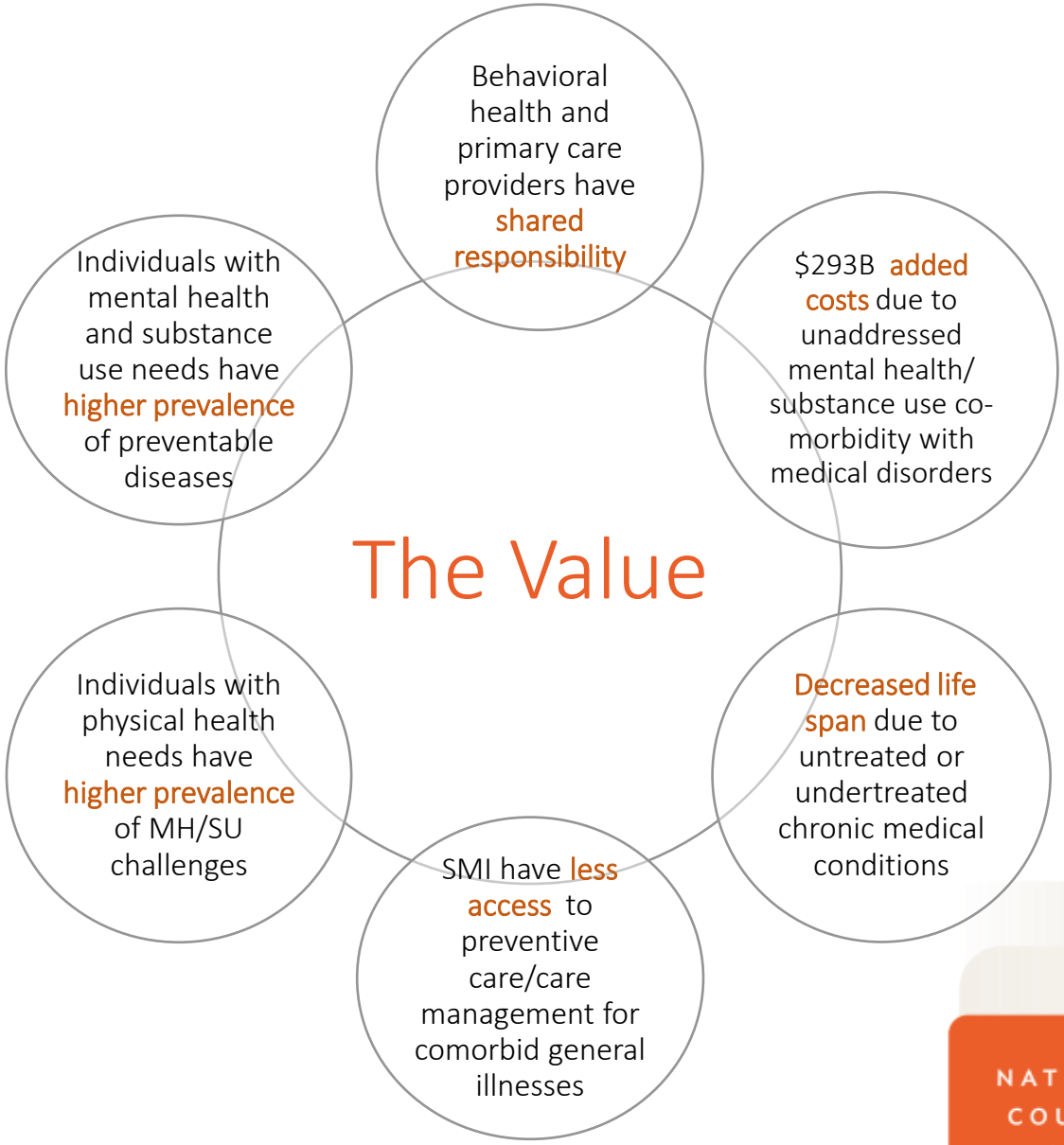
Why Integrated Care?

Where are we going and how do we get there?

The Comprehensive Health Integration Framework

Why Integrated Care?



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CENTER OF EXCELLENCE for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Advancing Integrated Care Through Training and Technical Assistance

To advance the implementation of **high quality, evidence-based treatment** for individuals with co-occurring physical and mental health conditions, including substance use disorders.

Provide training, resources, and technical assistance to health practitioners and other stakeholders addressing the needs of individuals with co-occurring physical and mental health conditions, including substance use disorders.

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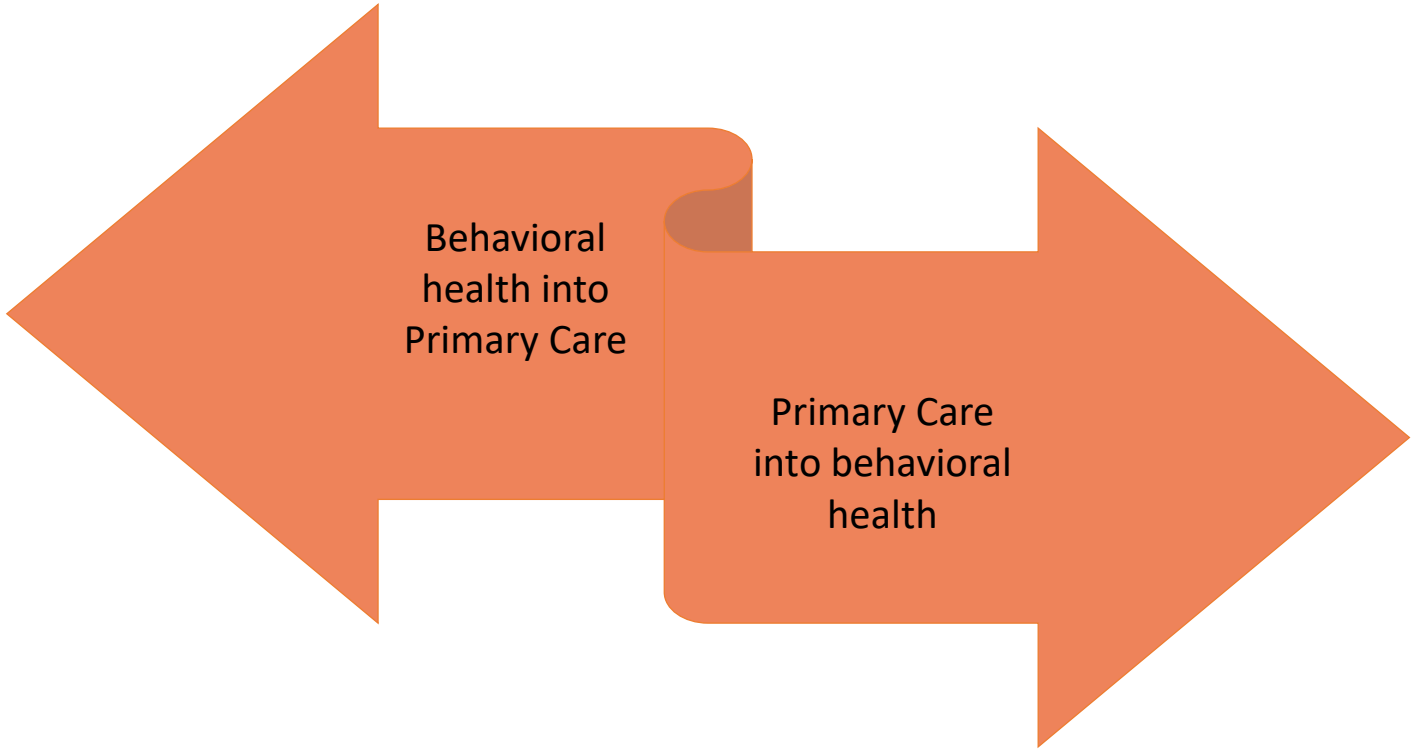
Current State of Implementation of Integration

Bi-Directional Integration is Critical



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Why do we need a new framework now?

- **People living with co-occurring Physical Health, Behavioral Health and SDOH needs:**
  - Have higher costs yet experiences poorer health outcomes
  - Are faced with significant inequities based on racial, ethnic, and economic challenges across all settings
  - Are likely to benefit from evidence-based integrated interventions in whatever setting they are best engaged
  - Benefit from higher levels of service intensity

- **Despite progress of knowledge about PH/BH integration, broad uptake remains more limited than the need for these services.**

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Overall Summary of Progress

Bi-directional integration knowledge growth

Implementation basic Conceptualization; Four Quadrants, SAMHSA Six Levels, IPAT

Models of Implementation; PCare, CoCM, PCMH

Modes of Implementation; PBHCI, CCBHC

Research delineating tools and procedures to support practice approaches

Evidence that demonstrates improved client outcomes

Disappointing Uptake after 15 Years of Work

- Many Healthcare organizations have not attempted to implement any of the current models
- Often implemented as an isolated special project/service instead of a whole organization transformation
- Often not sustained or expanded beyond initial grant funding

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Bipartisan Policy Center Report

The 2021 BPCR recognized policy barriers that prevent the advancement of integrated care in all PH and BH services, and recommended the following:

- Define a set of core service elements
- Identify a set of standardized quality and performance metrics
- Incentivize CCBHCs and FQHCs
- Incentivize Medicaid and Medicare
- Develop core integrated care measures

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Policy and Implementation Barriers

- **Lack of flexibility in implementation of integrated services**
- **Lack of appropriate bi-directional measures of progress in “integratedness”**

- **Lack of connection of “integratedness” to value**
- **Lack of financing to support either implementation or sustainability**

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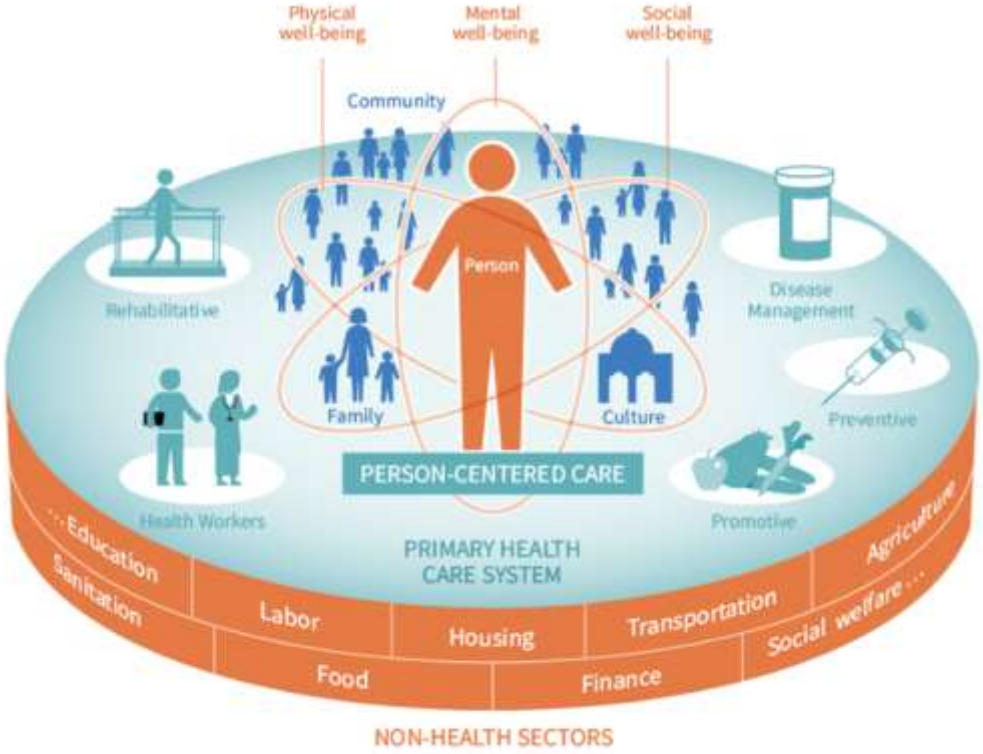
Comprehensive Healthcare Integration (CHI) Framework

What is the CHI Framework?

The CHI Framework provides guidance on implementing the integration of physical health and behavioral health to help providers, payers and population managers:

- Measure progress in organizing delivery of integrated services (“integratedness”)
- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integration



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Integrated Services

- The provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions, along with attention to SDOH, in the setting in which the person is most naturally engaged.

Integratedness

- The degree to which programs or practices are organized to deliver integrated PH and BH prevention and treatment services to individuals or populations, as well as to address SDOH.

- A measure of both structural components (e.g., staffing) and care processes (e.g., screening) that support the extent to which “integrated services” in PH or BH settings are directly experienced by people served and delivered by service providers.

Integration is not produced or defined by:

1. Consolidating separate funding for PH and BH care.
2. Putting PH and BH services under the same lines of authority in the table of the organization.
3. Co-locating PH and BH services in the same building.
4. Contracting with a managed care organization to manage both PH and BH services.

None of the above is either necessary or sufficient to produce meaningfully integrated services.

Policymakers and payers should NOT assume that if they consolidate funding and authority at either the payer or provider level, integration will somehow occur due to market forces.

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Achieving Integratedness

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Characteristics of the CHI Framework

- ✓ Broad application to both PH and BH settings, and adult and child populations
- ✓ Evidence-based domains of integration
- ✓ Measurable standards for integration
- ✓ Self-Assessment Tool
- ✓ Flexibility of achieving successful progress in integration
- ✓ Connection of progress in integration to metrics demonstrating value
- ✓ Connection of payment methodologies to improving value by improving and sustaining integration

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Components of the CHI Framework

- **Eight Domains** – Care processes related specifically to addressing physical health and behavioral health issues in an integrated manner.
- **Three Constructs** - Each Integration Construct describes an organized approach that has several evidence-based or consensus supported core service elements for "integratedness" tied to the indicators on the Eight Domains, each of which can be implemented flexibly depending on the capabilities of a provider organization and the priority needs of the population served.
- **Integration Metrics** – Measuring the degree of integratedness in care delivery and the improvement in outcomes from implementing integration that ties each Integration Construct to Value.
- **Integration Payment Methods** – Demonstrating how to cover costs of implementing and sustaining integration for each Integration Construct, incentivizing creating value through financing integration

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Eight Domains of Integration

Integrated Screening, Referral, and Follow-up

Prevention and Treatment of PH/BH Conditions

Care coordination and Care Management

Self-Management Support

Multi-Disciplinary Teamwork

Systematic Quality Improvement

Linkage with Community and Social Services

Sustainability

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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 [MH], substance use disorder [SUD], nicotine), physical health (PH) conditions and preventive risk factors.	Response to patient self-report of co-occurring behavioral health (BH) and/or PH complaints.	Systematic screening for high prevalence BH and/or PH conditions and risk factors.	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.	Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and analysis of patient population stratified by severity of PH/BH complexity.
	1.2 Facilitation of referrals and f/u.	Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.	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.	Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team or a behavioral health consultant (BHC) for a primary care team to ensure follow-up and coordination with access to well-coordinated referrals.	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 with automated data sharing and accountability for engagement.

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**
3. Ongoing Care Coordination and Care Management.	**3.1** Longitudinal clinical monitoring and engagement for addressing prevention and intervention for co-occurring PH and/or BH conditions.	No/minimal mechanisms for routine coordination and f/u of patients referred to PH or BH care.	Provider team has mechanism for tracking f/u to appointments with PH/BH referrals, navigating to appointments encouraging adherence to care	Team members who use measures to guide care and plan. Assigned team member(s) who can provide routine care coordination and monitor routine proactive f/u and tracking of patient engagement, adherence and progress in co-occurring PH and/or BH services to ensure engagement and response.	Availability of a continuum of care coordination, involvement of consulting specialists like a BHC or RN care manager based on stratification of need for populations served. Use of tracking tool to monitor treatment response and outcomes at individual and group levels.

Three Integration Constructs: Core Components

- Describes an approach that has several evidence based or expert consensus supported core service elements drawn from the eight domains for “integratedness”
- Can be implemented flexibly depending on the mission, resources, incentives and capabilities of a provider organization.
- Are adaptable with some degree of consistency by organizations whose initial targets may range more basic to more advanced integratedness based on available resources.
- The names of the Constructs are driven by the Domains’ primary integratedness workflows implemented to either measurably improve health outcomes or measurable processes that have been shown to directly result in improved health outcomes.

The Three Integration Constructs

Integration Construct 1:
Screening and Enhanced Referral

- Optimizes screening and "enhanced" referral processes
- Does not require significant investment
- Best practice for smaller practices/programs with fewer resources

Integration Construct 2:
Care Management and Consultation

- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and are management

Integration Construct 3:
Comprehensive Treatment and Population Management

- Typically requires comprehensive PH and BH staffing in a single organization (hospital, independent clinical practice, FQHC, etc.)
- Measures improved health outcomes along the Domains

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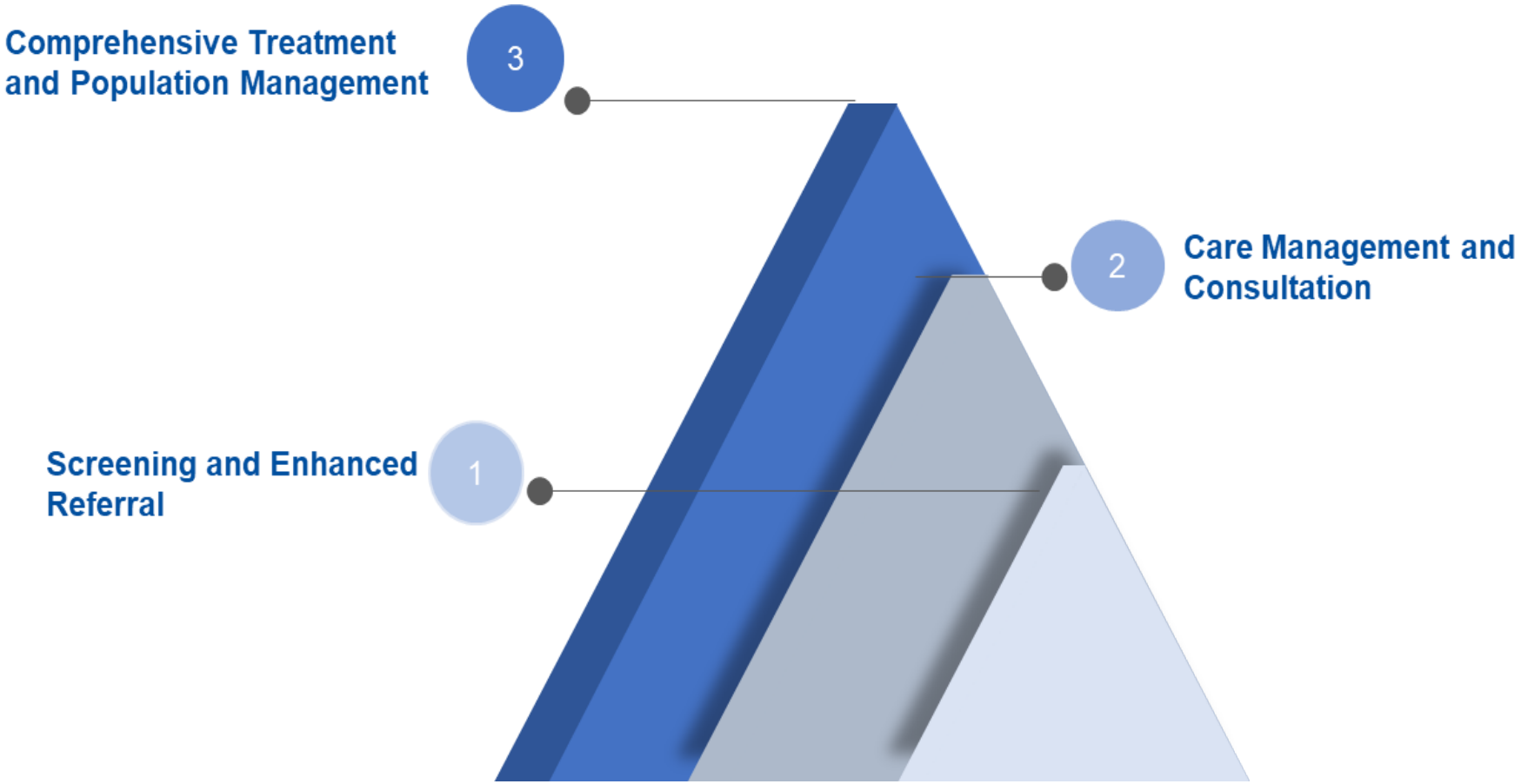
The Three Integration Constructs



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Examples of Program Implementation Within the Three Integration Constructs

Screening and Enhanced Referral	Care Management and Consultation	Comprehensive Treatment and Population Management
Pcare (Druss, 2010)	Primary Care Behavioral Health Model PC	
PRISM-e (Krahn,2006; Bartels, 2004)	ACA Section 2307 health homes for chronic conditions	Primary Care-Mental Health Integration (PC-MHI) in the U.S. Veteran's Administration
Primary Care Case Management	Collaborative Care Model	Montefiore Health System ACO
	Certified Community Behavioral Health Centers	Services for the Underserved (New York City) – combining FQHC and Community Mental Health Center (CMHC) programs

Demonstrating Value Using CHI

Definition of Value: Measurable improvement in individual or population health, BH or PH outcome measures and/or increased equity and quality in relation to expenditure.

Identify one or more co-occurring conditions and/or populations to address through integrated service delivery.

Implementation of measurable indicators of integratedness and relevant outcome metrics for those conditions

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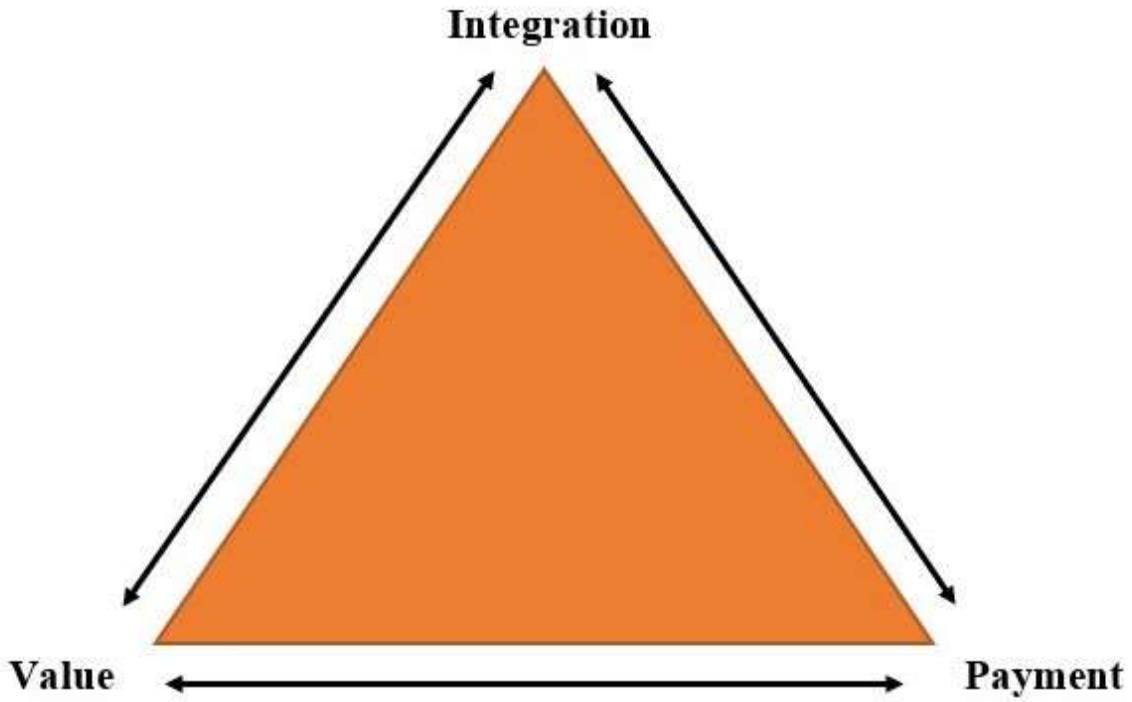
Defining how EACH Integration Construct Produces Value



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Choosing Metrics that Demonstrate Value

Selection of metrics and targets for those metrics will be a shared process between providers and payers.

Choose a balanced set:

1. One or more metrics focusing on prevention and/or treatment of PH conditions.
2. One or more metrics focusing on prevention and/or treatment of BH conditions.
3. One or more metrics that may apply to both (e.g., follow-up within 7 days of hospital discharge, all-cause readmissions, medication reconciliation and cross-communication).

Metrics for Integration Construct 1 – Screening and Enhanced Referral

BH Settings

- Screening rates for cardiovascular disease or diabetes in people with serious mental illness (per ADA/APA guidelines and HEDIS).
- Demonstration of at least one Care Compact or MOU with a PH provider to provide PH care and percent with completed referral (clinical documentation of lab, notes) received from referral organization.

PH Settings

- Screening rates for select groups – depression in adults and adolescents, attention deficit disorder in children and adolescents, anxiety disorders in children, adolescents and adults, Substance use disorders in adults and adolescents (SBIRT approach).
- Demonstration of at least one Care Compact or MOU with a BH provider to provide BH care
- Percent with completed referral (clinical documentation of notes) from referral organization.

Metrics for Integration Construct 2 – Care Management and Consultation

Includes metrics from Construct 1

BH Settings	PH Settings
• Percentage of child and adolescent patients with elevated BMI offered nutritional counseling. • The percentage of patients with OUD prescribed MAT with six, 12, 18 months (could be in PH or BH column. • Percentage of patients with SMI and diabetes demonstrating control (A1c < 9).	• Percentage of patients (adult and adolescent) diagnosed with depression with a 50% reduction in depression symptoms utilizing a validated too (PHQ9 for example) at 6 and 12 months (NQF 1884 and 1885). • Percentage of the above that reach remission by six and 12 months (NQF 710 and 711).

Metrics for Integration Construct 3 – Comprehensive Treatment and Population Health

Includes metrics from Constructs 1 and 2

BH Settings	PH Settings
• Reduced utilization of ED and inpatient, • Improved follow-up post ED and inpatient • Reduction in 30-day readmissions, • Total cost of care.	• Reduced utilization of ED and inpatient, • Improved follow-up post ED and inpatient • Reduction in 30-day readmissions, • Total cost of care.

Financing Goals

Financing implementation

- Initial implementation of an Integrated Construct: *example-staffing, care processes and infrastructure needed to provide Integration Construct 1 (Screening and Enhanced Referral).*
- Strengthening an existing Construct: *by adding more types of conditions or interventions, expanding access of those interventions to a higher percentage of the population served and/or increasing the outcome targets for the interventions provided.*
- Incentivizing progress from one Construct to the next*: supporting investment in necessary staffing, technology, infrastructure and change management to make progress in the relevant CHI Framework Domains.*

Financing sustainability

- Provide continued support for maintaining an existing level of integratedness via current provision of a specific Construct for a particular set of issues in a defined population.

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Types of Payment Methodologies for Integration

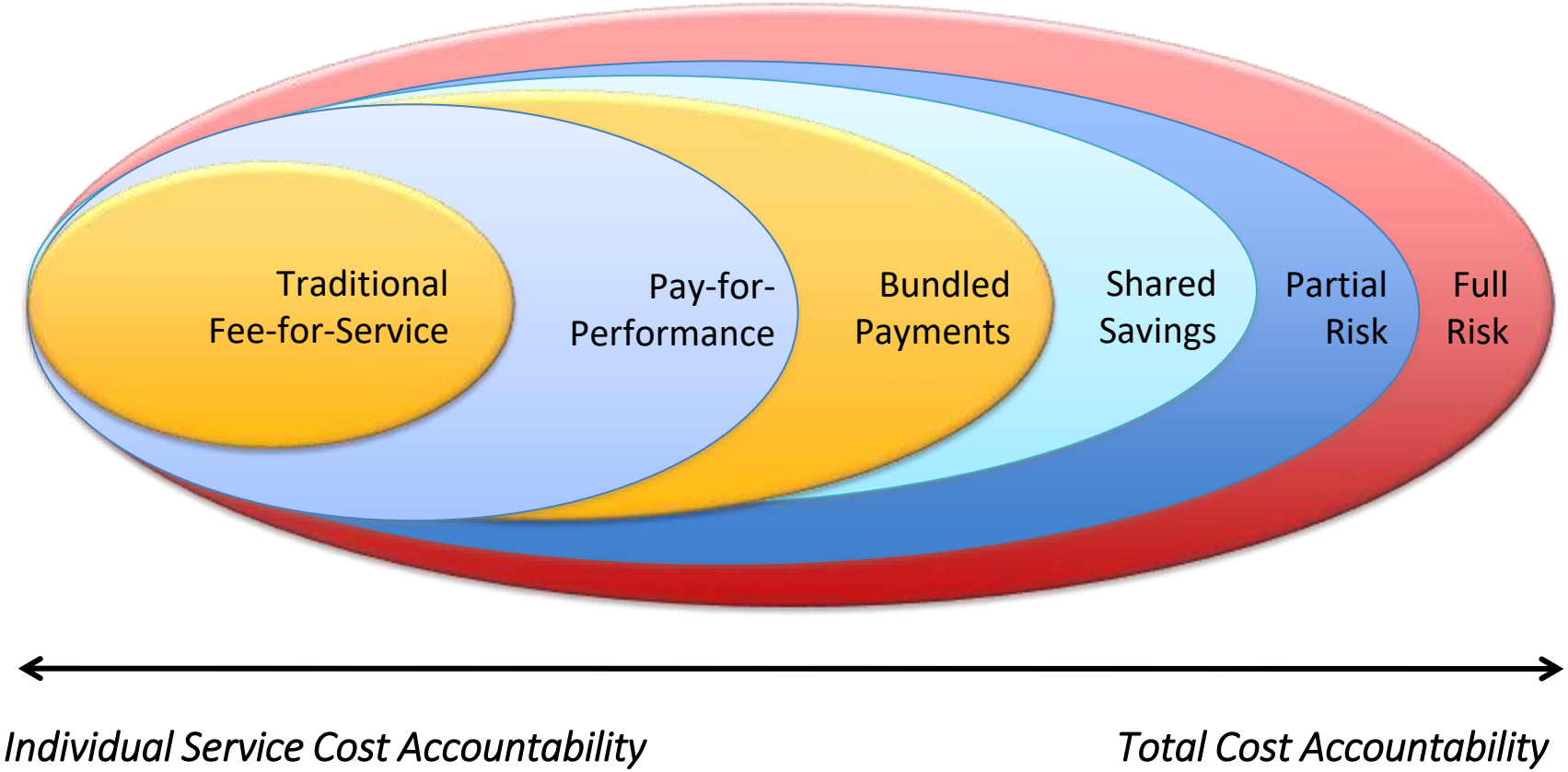
Current Procedural Terminology (CPT) Service Code Payments (usually fee-for-service).

- Single Service payment codes: (e.g., screening, individual care coordination, etc.)
- Bundled service payment codes: (e.g., COCM, Medication treatment for opioid use disorder, etc.)

Care Enhancement Payments (usually PMPM or PPS): a bundled payment for provision of specific service structures and processes, for the entire population served or (for per member per month) for a defined population.

Value-based payments (VBPs): usually a supplemental payment for achieving a prospectively determined value target. Provides reward (and sometimes penalty) linked to achieving clinical quality process or outcome goals and/or cost savings goals. For entities engaged in population management, this approach usually also involves capitation payments with some level of risk sharing.

Types of Payment Methodology



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Matching Payment Methodology to Sustainability of Each Integration Construct

Integration Construct 1 – Screening and Enhanced Referral

- A time-limited start up grant to cover initial implementation costs
- CPT code services that specifically support integration with rates set to adequately cover costs and incentivize uptake.
- Value-based incentive payment for timely implementation of the necessary screening and referral structures or performance measures related to screening and referral

Matching Payment Methodology to Sustainability of Each Integration Construct – 2

Integration Construct 2 – Care Management and Consultation

- A time-limited grant to cover implementation costs of evidence-based integration programs
- Bundled Care Enhancement Payments with rates set to adequately costs of the specified staffing and integration processes

Matching Payment Methodology to Sustainability of Each Integration Construct - 3

Integration Construct 3 – Comprehensive Treatment and Population Management

- Substantial access to Care Enhancement payment or risk-based capitation payment
- Value-based incentive payments for integration processes and outcomes

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Provider Recommendations

Utilize	Improve	Implement	Improve	Include	Exchange
Utilize the CHI framework at a program/population level to assess your current state of integration	Improve proficiency in quality metric selection relevant to Framework Domains and Constructs, workflow improvements and progress to goal.	Implement BH and PH enhanced referral pathways per the CHI Framework screening and referral Domain	Improve proficiency in using the available billing and coding procedures and visit types.	Include primary care and behavioral staff in joint integration training.	Proactively exchange PHI with other healthcare providers to assure integration of care to the extent allowable under current regulation

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Payer Recommendations

Utilize the CHI Framework to organize continuous quality improvement for integrated services delivery.	Utilize payment methodologies that cover integration start-up costs.	Utilize payment methodologies that provide sustainability of integration. Set care management and/or bundled rates that are adequate to cover costs.	Match payment methodology to the Integration Construct.
Eliminate or reduce patient co-pays that obstruct integration.	Proactively exchange relevant Protected Health Information (PHI) with your contracted healthcare providers to support integration efforts as allowable under current regulation	Provide equity for BH provider eligibility for integration payments.	Educate providers on billing codes available to support integration.

Recommendations for Policymakers

Leverage the CHI Framework at the state and local level to understand and remove challenges to integratedness implementation and revise regulatory requirements obstructing integration.
Eliminate all prohibitions on billing for a primary care and BH service on the same day.
Use the CHI Framework as guidance for measuring progress.
Improve coverage and rates for CPT code payments that support integration.
Expand and incentivize CCBHCs and FQHCs to provide integrated care services and measures according to the CHI Framework and Constructs.
Incorporate the CHI Framework into consultation and technical assistance at the federal, state, tribal and local levels.
Adopt all-payer integration initiatives using the CHI Framework to improve evaluation of processes and outcomes and reduce variability across payers.

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CHI Framework Learning Opportunities

Available to download now: https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

- Spring 2022 CoE Webinars:

  April 27, Webinar #1 – *Comprehensive Health Integration Part 1: Introducing a New Framework*

  May 25, Webinar #2 – *Comprehensive Health Integration Part 2: Domains and Constructs*

  June (TBD), Webinar #3 – *Comprehensive Health Integration Part 3: Measuring Integration & Choosing Metrics*

  July (TBD), Webinar #4 - *Comprehensive Health Integration Part 4: Payment Models for Comprehensive Health Integration*

  Visit the Events Page, on the COE-IHS to register!

  https://www.thenationalcouncil.org/program/center-of-excellence/

- Winter 2022 ECHO - Learning Community

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Questions & Comments?

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Tools & Resources

National Council for Mental Wellbeing

- CHI Framework - https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/
- Center of Excellence for Integrated Health Solutions – Resource Home Page
- CIHS Standard Framework for Levels of Integrated Care
- CIHS Essential Elements of Effective Integrated Primary Care & Behavioral Health Teams
- General Health Integration Framework – Advancing Integration of General Health in BH Settings
  - Utilizing an Evidence-based Framework to Advance Integration of General Health in Mental Health and Substance Use Treatment Settings – Blog post
- Medical Director Institute – Home Page
- High-Functioning Team-Based Care Toolkit
- Organizational Assessment Toolkit for Primary & Behavioral Health Care Integration (OATI)
- Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

Other

- Agency for Healthcare Research & Quality – Implementing a Team-Based Model in Primary Care Learning Guide
- Health & Medicine Policy Research Group – Behavioral Health Primary Care Integration

Upcoming CoE Events:

CoE-IHS Webinar: Pregnant & Post-Partum People Part 1

Register for the Webinar on Tuesday, May 10, 1-2pm ET

CoE-IHS Webinar: Pregnant & Post-Partum People Part 2

Register for the Webinar on Tuesday, May 13, 1-2pm ET

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