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Comprehensive Health Integration Part 3: Measuring Integration and Choosing Metrics

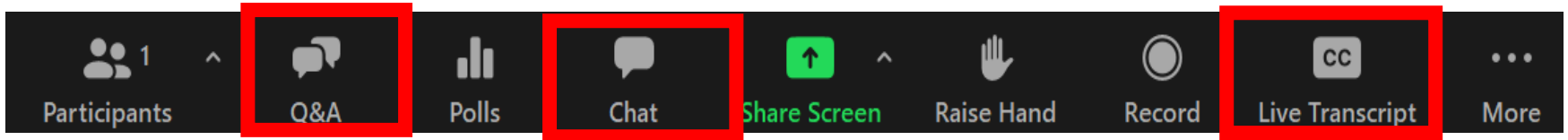
Tuesday, June 28th
2-3pm EDT

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

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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SAMHSA

Substance Abuse and Mental Health Services Administration

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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)

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Introductions

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ZiaPartners

Lori Raney, MD
Owner, Collaborative
Care Consulting

Jeffrey Eisen, MD, MBA
Chief Medical Officer
Behavioral Health
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Learning Objectives

After this webinar, participants will be able to...

- Identify domains of integration applicable to both primary care and behavioral health care.
- Discuss how to use the Comprehensive Health Integration (CHI) 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 making integration operational and visible within your organization.
- Identify at least one new payment methodology to support integration within your organization.

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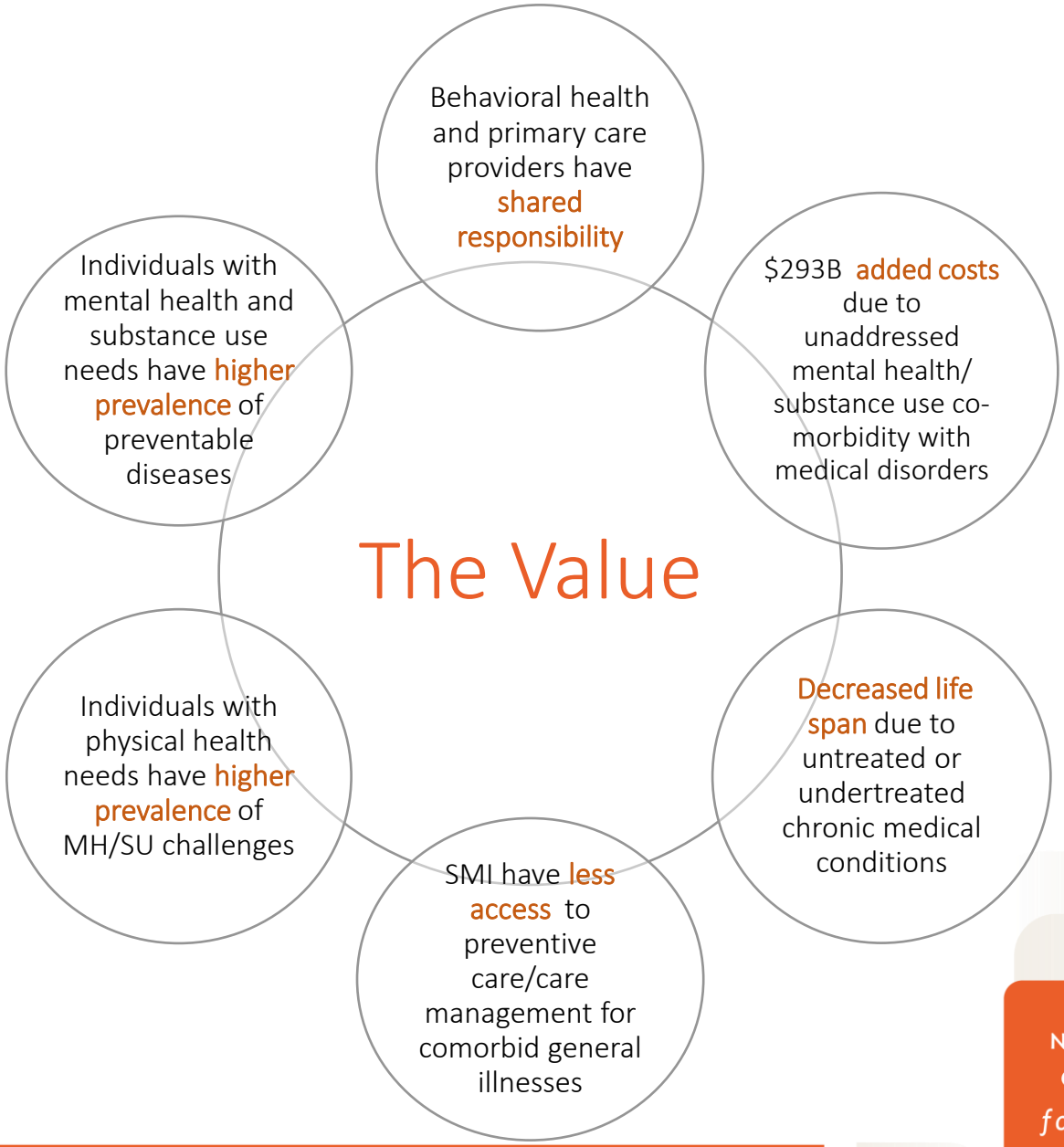
Why Integrated Care?

Where are we going and how do we get there?

The Comprehensive Health Integration Framework

Why Integrated Care?



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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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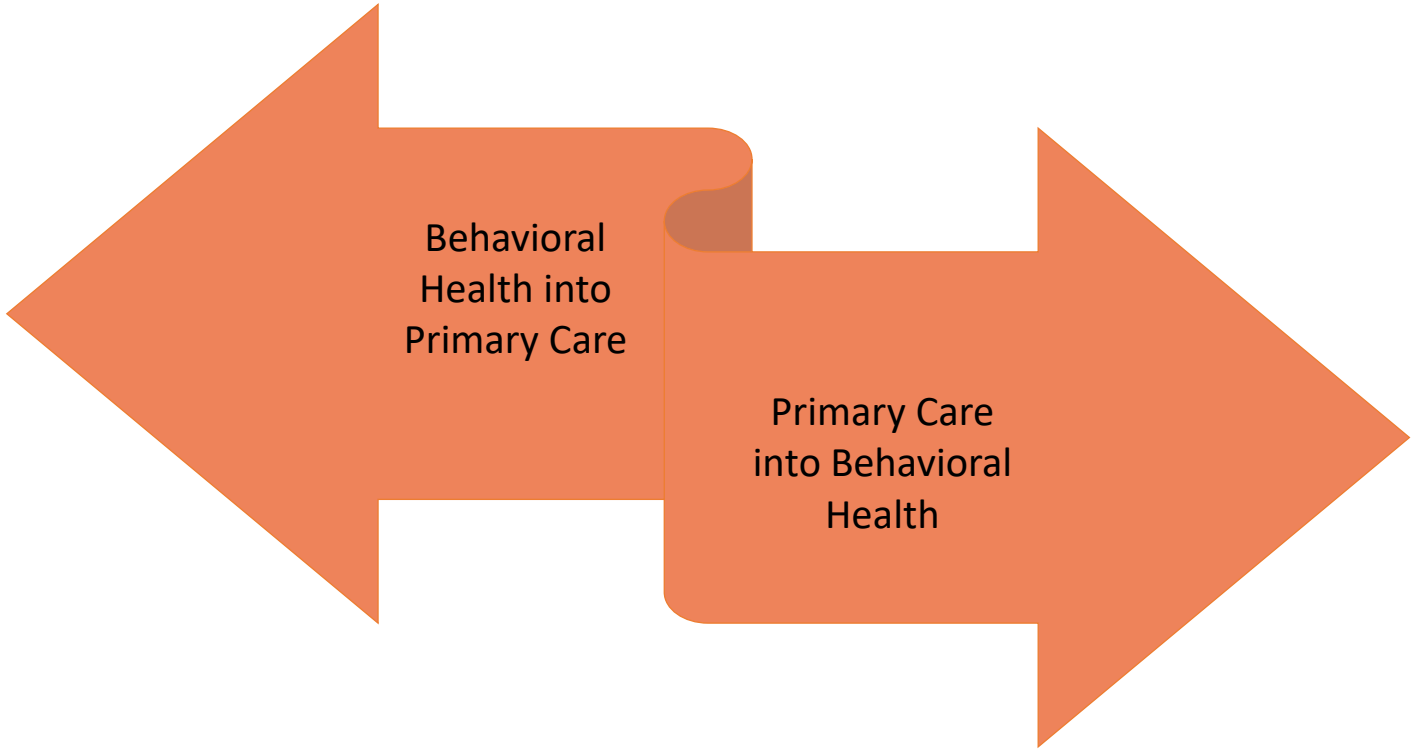
Current State of Implementation of Integration

Bi-Directional Integration is Critical



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Why do we need a new framework now?

People living with co-occurring Physical Health (PH), Behavioral Health (BH) and Social Determinants of Health (SDoH) needs:

- Have higher costs yet experience 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

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Disappointing Uptake after 15 Years of Work

- Many healthcare organizations have not attempted to implement any of the current models.
- Models are often implemented as an isolated special project/service instead of a whole organization transformation.
- Efforts are 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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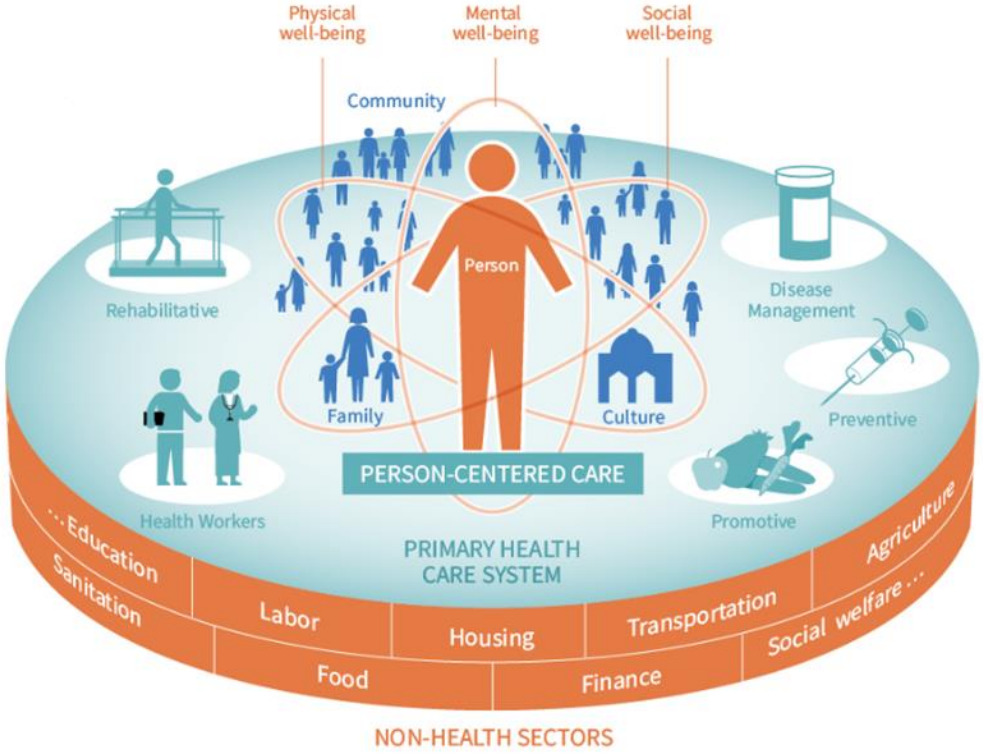
Comprehensive Healthcare Integration (CHI) Framework

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

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 →			
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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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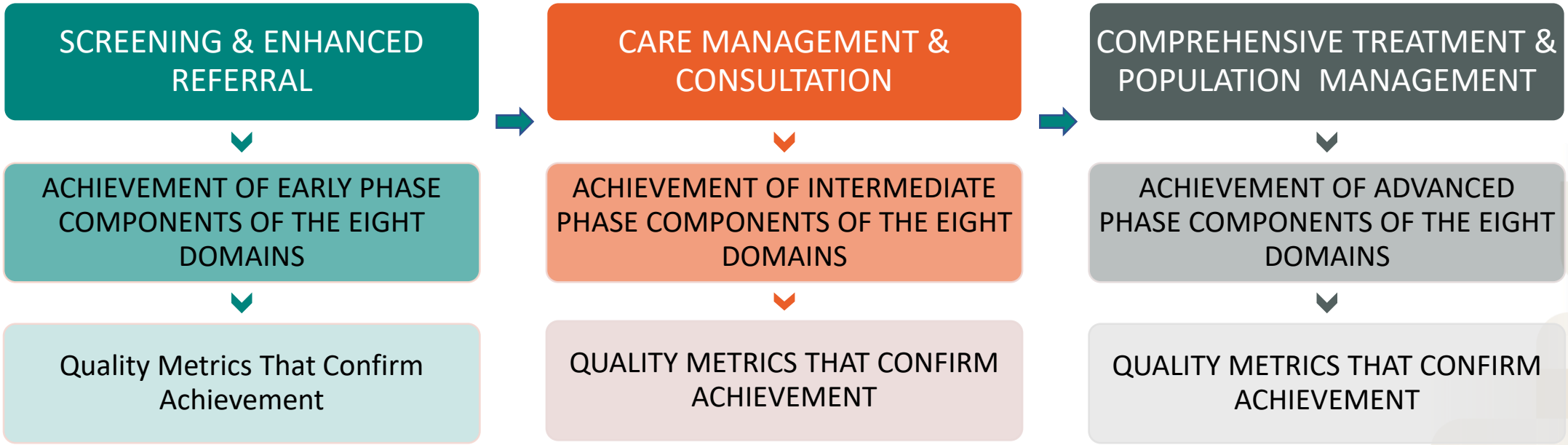
Eight Evidenced Based Integration Domains Within Each of the Three Integration Constructs



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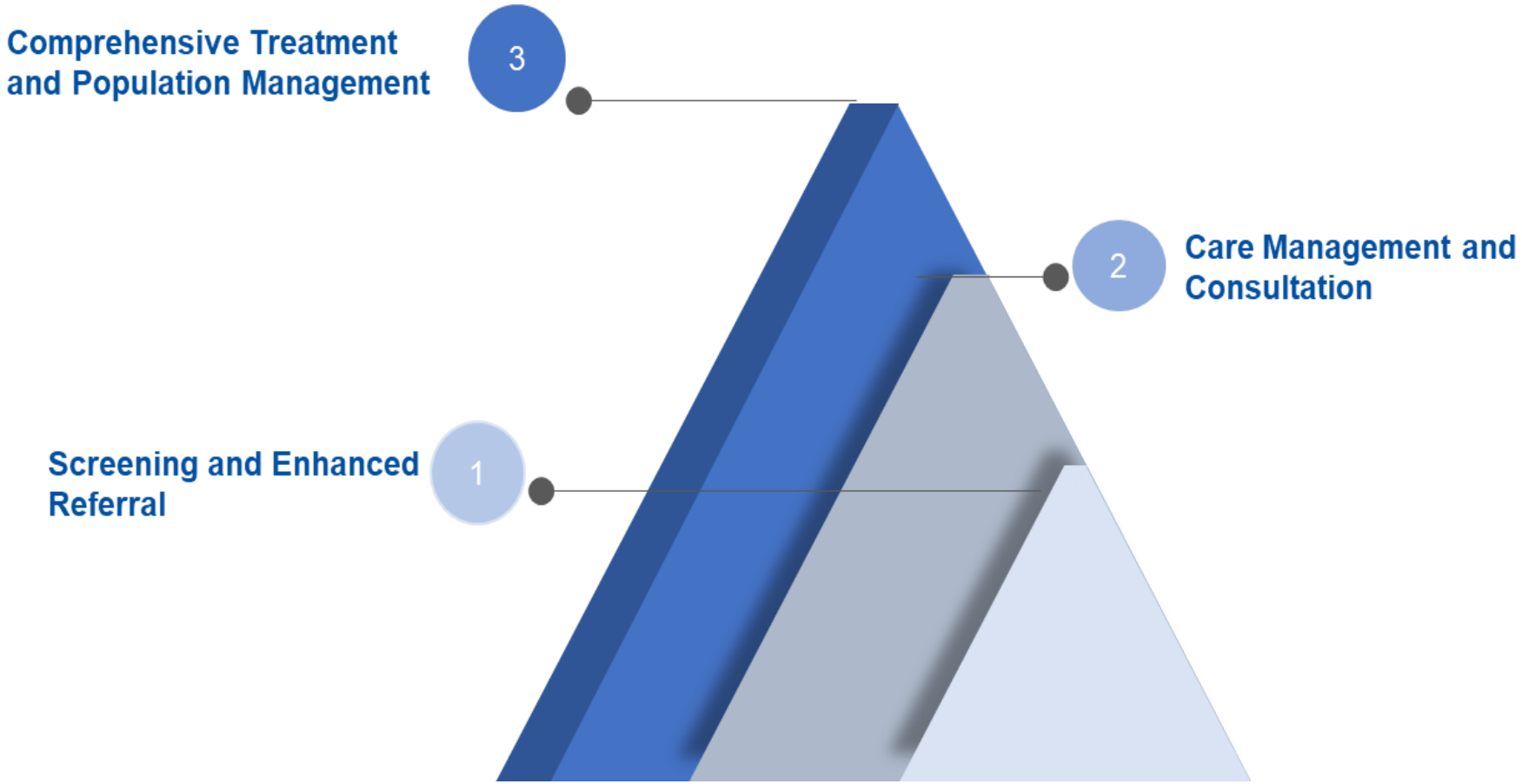
The Three Integration Constructs



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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

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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.

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2. Evidence-based (EB) care for prevention/ intervention for common PH and/or BH conditions.	**2.1** EB guidelines or protocols for preventive interventions such as health risk screening, suicide risk screening, opioid risk screening, developmental screening.	No/minimal guidelines or protocols used for universal PH or BH preventive screenings. No/ minimal training for providers on recommended preventive screening.	Routine use of EB or consensus guidelines for performing or referring for risk factor screenings with basic training for providers on screening and result interpretation. Coordination with outside providers for any preventive activities.	Routine use of EB or consensus guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results.	Prescribers more regularly initiate and manage a range of medications for common co-occurring PH or BH conditions, including medication treatment for SUD, with routine consultation and collaboration with "co-occurring" consultant.
	2.2 EB guidelines or treatment protocols for common PH or BH conditions.	No/minimal guidelines or EB workflows for improving access to care for PH and/or BH conditions.	Intermittent/ limited use of EB guidelines and/or workflows for treatment of common PH and/ or BH conditions, with limited monitoring.	Provider team including embedded BH or PH consultant, if any, routinely use EB/consensus guidelines or workflows for patients with PH and/or BH conditions. Systematic measurement of symptoms used.	See Integration Construct 2 plus evidence of treating more than one condition (in collaboration with a consulting psychiatric or physical health provider).
	2.3 Use of medications by prescribers for common PH and/ or BH conditions, including tobacco cessation.	No/limited use by prescribers of medications for co-occurring PH or BH conditions.	Prescribers routinely provide medications for tobacco cessation and will continue to prescribe stable medications for co-occurring PH or BH conditions for a limited number of individuals.	Prescribers will occasionally initiate medications for selected co-occurring conditions, including medication treatment for SUD. Initiation of first line antidepressants, anti-anxiety and attention deficit disorder medications by most PCPs in a practice. Documentation or formal contract with psychiatric consultant.	
	2.4 EB or consensus approaches to addressing trauma and providing trauma-informed care.	Staff have no/minimal awareness of effects of trauma on PH and BH care and no systematic application of person-centered trauma-informed practice.	Basic education of provider team on impact of trauma on PH and BH and use of person-centered, trauma-informed approaches to engaging people with complex needs.	Ongoing implementation of person-centered trauma-informed care models.	Adoption of trauma-informed care strategies, treatment and protocols by treatment team at all levels. Routine use of validated trauma assessment tools.

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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.

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4. Self-management support that is adapted to culture, socio-economic and life experiences of patients.	**4.1** Use of tools to promote patient activation and recovery from co-occurring PH and/ or BH conditions with adaptations for literacy, economic status, language, cultural norms.	No/minimal patient/family education on PH/BH conditions, PH/BH healthy behavior skills and PH/ BH risk factor screening recommendations.	Some availability of patient/family education (handouts, web-based, etc.) on PH/ BH conditions, PH/ BH healthy behavior skills and PH/ BH risk factor screening recommendations.	Routine brief patient/family education delivered in-person or technology application on selected PH/BH conditions, PH /BH healthy behavior skills and PH/BH risk factor screening recommendations.	Routine and ongoing patient/family education on PH/BH conditions, PH/BH healthy behavior skills and PH/BH risk factor screening recommendations throughout the service continuum with strategies for patient activation and healthy lifestyle habits.

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5. Multi-disciplinary team (including patients) with dedicatedtime to provide integrated PH/BH care.	**5.1** Care team.	Provider team, patient, family caregiver (if appropriate).	Provider team patient, family caregiver. Possibly care coordinator or manager.	BH consultant(s) and care coordinators available to PH team. PH consultant (nurse/ care manager) available to BH team. Should have access to a BH psychiatrist/nurse practitioner (NP) or a PCP.	PH/BH staff, with care managers, peers/community health workers (CHWs), working as integrated teams throughout the continuum with patients/families.
	5.2 Sharing of treatment information, case review, care plans and feedback.	No/minimal routine sharing of treatment information and feedback between BH and PH providers in different settings.	Routine release and exchange of information (phone, fax) between PH and BH referral providers without regular chart documentation.	Discussion of assessment and treatment plans in-person, virtual or by telephone when necessary and routine PH and BH notes in EHR visible for routine reviews.	Regular in-person, phone, virtual or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans.
	5.3 Integrated care team training and competency development.	No/minimal training of all staff levels on integrated care approach and incorporation of PH/BHI concepts.	Basic training of all staff levels on integrated care approach and incorporation of integrated care concepts and screening/referral workflows.	Routine training of all staff levels on integrated care approach and incorporation of integrated care activities into integrated teamwork with role accountabilities defined for each team member.	Routine integrated team processes like huddles and care meetings. Systematic continuing training for all staff levels that target areas for improvement.

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6. Systematic quality improvement (QI).	**6.1** Use of quality metrics for PH/BH integration improvement and/or external reporting.	No/minimal use of PH and/or BH quality metrics	Limited tracking of co-occurring PH and/or BH quality metrics for people served and/or for state or health plan reporting. Some ability to report and track improvement for group level issues.	Routine periodic QI monitoring of identified PH and/or BH quality process and outcome metrics, ability to regularly review performance against benchmarks and attempt to improve performance as needed.	Routine incorporation of PH/BH measurement into organizational QI with ongoing systematic monitoring of population level performance metrics, ability to respond to findings using formal improvement strategies and routine implementation of improvement projects by QI team/champions with demonstration of progress.

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7. Linkages with community and social services that improve BH and PH and/or mitigate environmental risk factors.	**7.1** Linkages to housing, employment, education, developmental disabilities and brain injuries (DD/BI), child/adult protective, domestic violence, financial entitlement, home care, immigration, other social support services.	No/informal screening of social determinants of health (SDOH) and linkages to social service agencies, no formal arrangements.	Routine SDOH screening and referrals made to social service agencies. Some referral and follow up, but few formal interagency arrangements established.	Routine SDOH screening, with formal collaboration arrangements and contacts established with commonly used social service agencies. Some capacity for follow-up tracking and service monitoring	Detailed psychosocial assessment incorporating broad range of SDOH needs. Patients and families routinely linked to collaborating social service organizations/ resources to help improve appointment adherence, with f/u to close the loop.

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8. Sustainability	**8.1** Build process for billing and process and outcome reporting to support financial sustainability of integration efforts.	No/minimal attempts to bill for co-occurring PH and/or BH screening, prevention, intervention conducted onsite. May have grants or other non-sustainable funding.	Billing for PH or BH screening and treatment services under fee-for-services with process in place for tracking reimbursements for PH and/or BH services.	Revenue from payments for developing capacity or for improving processes through quality incentives related to PH or BH. Able to bill some bundled rates for specialized services such as collaborative care management (COCM) or medication-assisted treatment (MAT).	Receipt of value-based payments that reference achievement of BH and PH outcomes for the population served. Revenue helps support necessary staffing, services and infrastructure to support the continuum.
	8.2 Build process for expanding regulatory and/or licensure opportunities.	Licensed and/or regulated as a PH or BH provider with no or limited understanding of how to provide integrated interventions for co-occurring diagnoses.	Established procedures for providing and documenting integrated screening and interventions that support what is allowed within single license.	Formalized ability to provide some level of integrated PH and BH services within a single license, as well as to coordinate and document internal or external service provision. Meets patient-centered medical home (PCMH) or BH health home standards.	Provides licensed PH and BH services in shared services settings throughout the continuum and regularly works to improve design and application of administrative or clinical licensure requirements and regulatory standards to support integrated care for the population served.

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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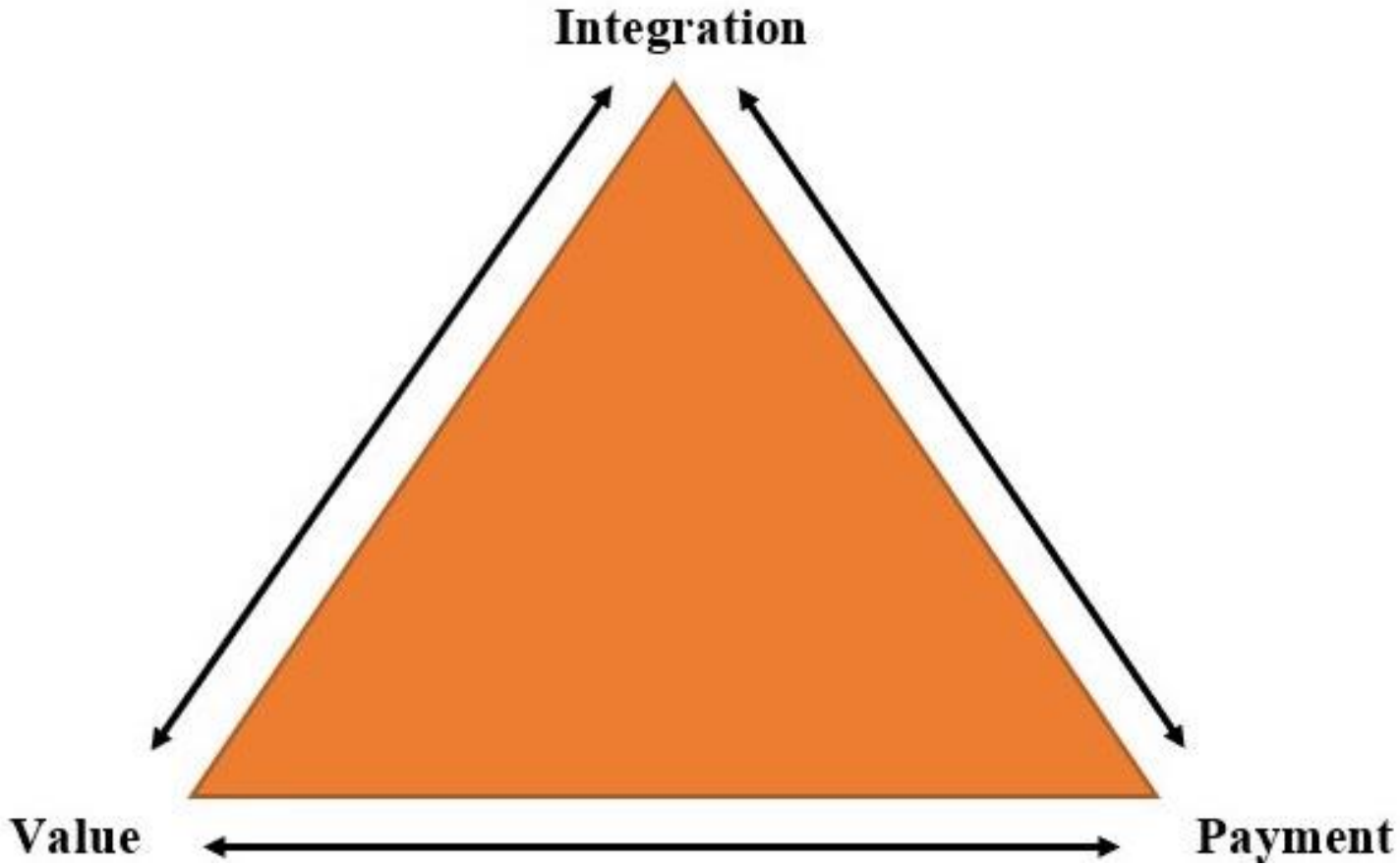
Defining how EACH Integration Construct Produces Value



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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).

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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.

Expert Insight – Dr. Jeffrey Eisen

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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:
  - Part 1: Introducing a New Framework, April 27 (View the recording here)
  - Part 2: Domains and Constructs, May 25 (View the recording here)
  - Part 3: Measuring Integration and Choosing Metrics, June 28 (View the recording here)
  - Part 4: Payment Models for Comprehensive Health Integration, July 27 (Registration link)

  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

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- CoE-IHS Webinar: Comprehensive Health Integration Part 1: Introducing a New Framework Recording
- CoE-IHS Webinar: Comprehensive Health Integration Part 2: Domains & Constructs Recording
- 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

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Upcoming CoE Events:

PCDC Webinar: The Art and Science of Integrated Care Partnerships

Register for the webinar on Tuesday, July 12th, from 2p-3:30p EST

CoE-IHS Webinar: Perinatal Health Part 4: Addressing Serious Mental Illness

Register for the webinar on Thursday, July 21st, from 2-3pm EST

CoE-IHS Webinar: CHI Part 4- Payment Models for Comprehensive Health Integration

Register for the webinar on Wednesday, July 27th from 1-2pm EST

Interested in an individual consultation with the CoE experts on integrated care?

Contact us through this form here!

Looking for free trainings and credits?

Check out integrated health trainings from Relias here

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Thank You

Questions?

Email integration@thenationalcouncil.org

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