Behavioral Health Integration:

Essential for Outcomes in the New Health Care System

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What are the Underlying Causes of Death in the United States?

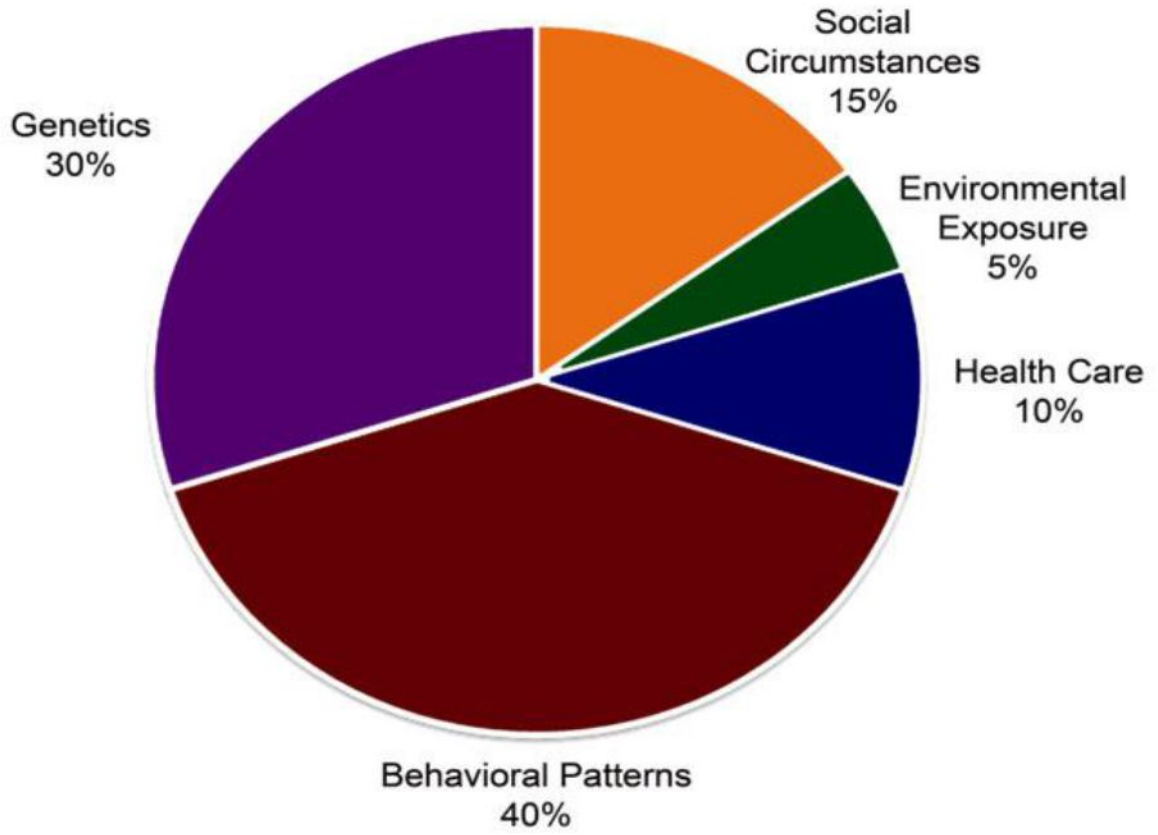
Areas that can be improved are:

1.) Health Care

- Care coordination
- Access

2.) Social Determinants

3.) Behavioral Health



Behavioral Determinants of Health

40%

of premature deaths in the United States are due to behavior.

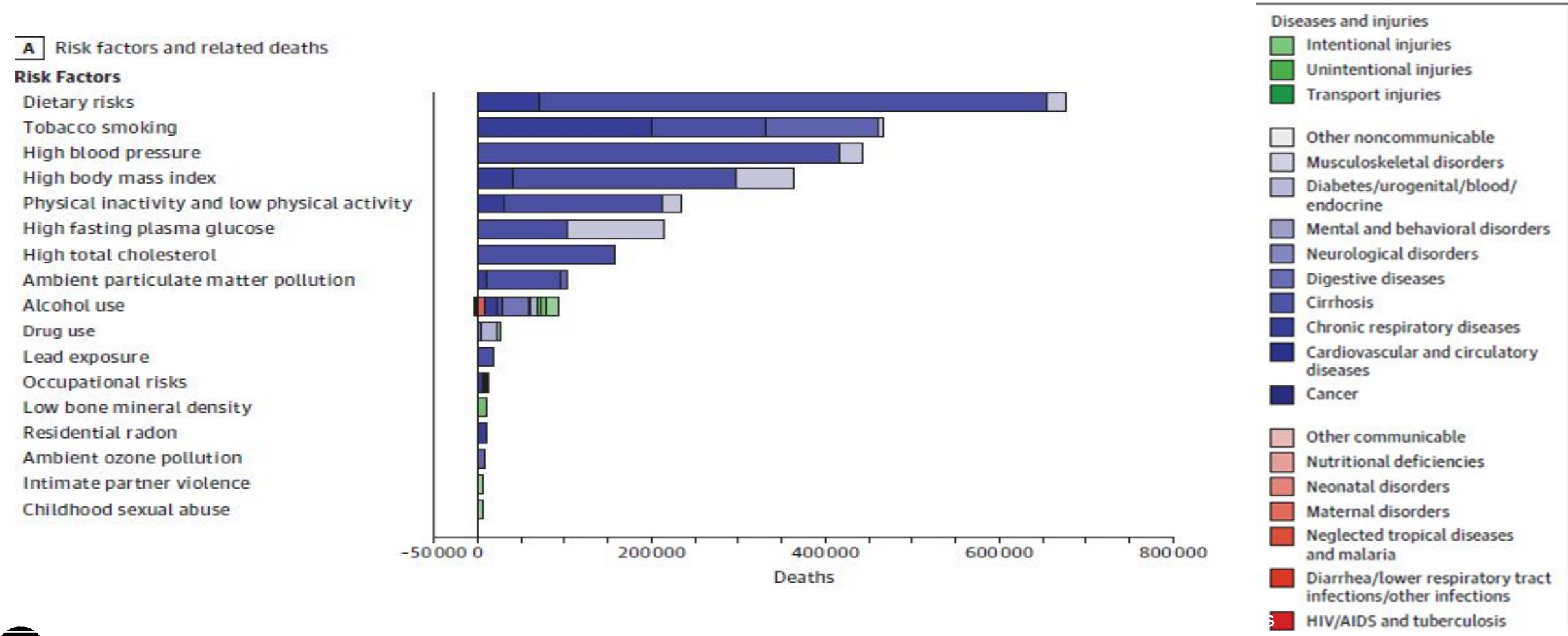
Behavioral Health Includes:

Healthy and Unhealthy Behaviors:
activity, stress, diet, medication adherence, and more

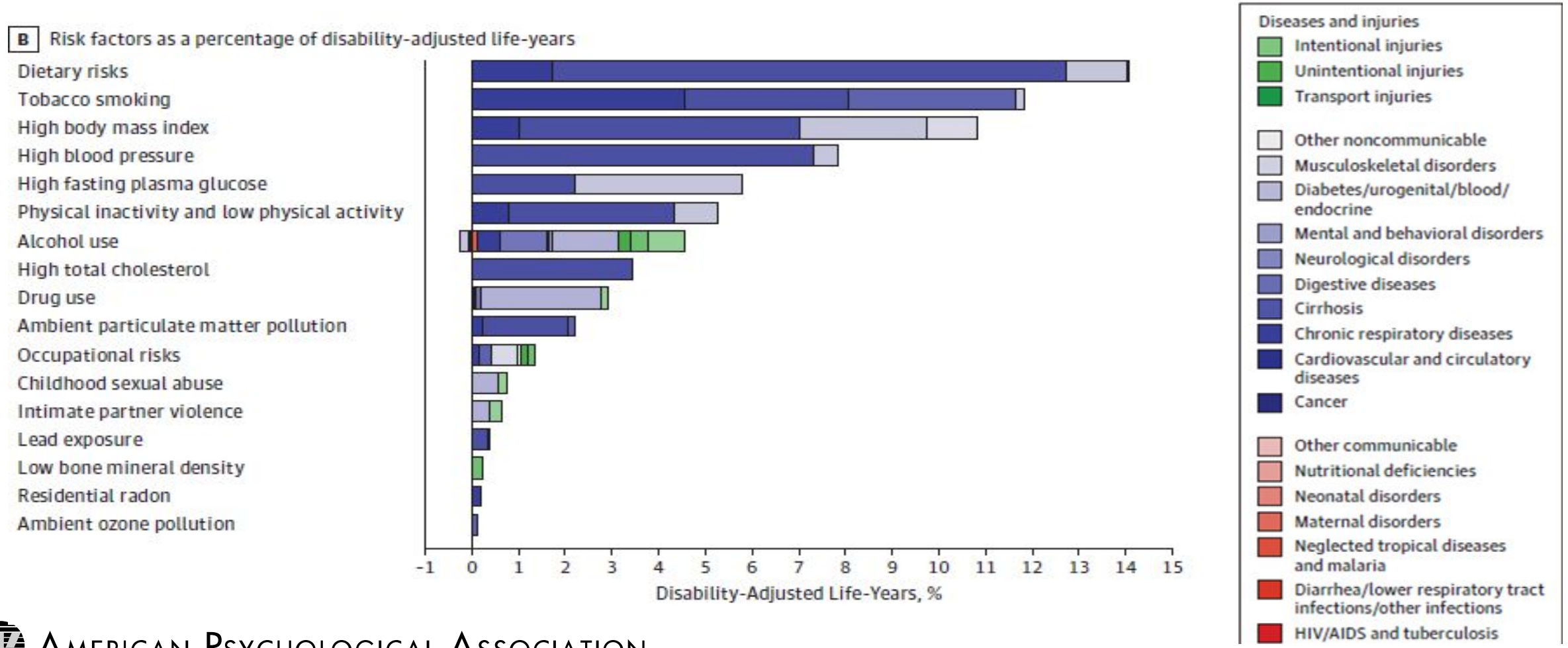
Mental Health:
psychological distress, depression, and anxiety to severe and persistent mental illness

Substance Use and Abuse:
smoking, using drugs, alcohol dependence

Healthy and Unhealthy Behaviors are primary risk factors for Early Deaths



Healthy and Unhealthy Behaviors are primary risk factors for Disability- Adjusted Life Years



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Source: Murray et al 2013 Figure 3: Number of Deaths and Percentage of Disability-Adjusted Life-Years Related to the 17 Leading Risk Factors I n the United States in 2010 for Both Sexes Combined

Health Care Costs, with or without Substance Abuse

Per Member Per Year (PMPY) Healthcare Costs by Population and Presence of Behavioral Conditions- 2012 costs

Population	Behavioral Health Diagnosis	Member Years	Medical	Behavioral	Medical Rx	Behavioral Rx	Total
Commercial	No MH/SUD	170,666,667	$3,360	$36	$636	$48	$4,080
	SUD	1,833,333	$9,960	$876	$1,224	$804	$12,864
Medicare	No MH/SUD	42,333,333	$6,948	$36	N/A*	N/A*	$6,984
	SUD	500,000	$15,492	$2,556	N/A*	N/A*	$18,048

* Pharmacy data not available for the Medicare population and the totals for Medicare do not reflect pharmacy costs

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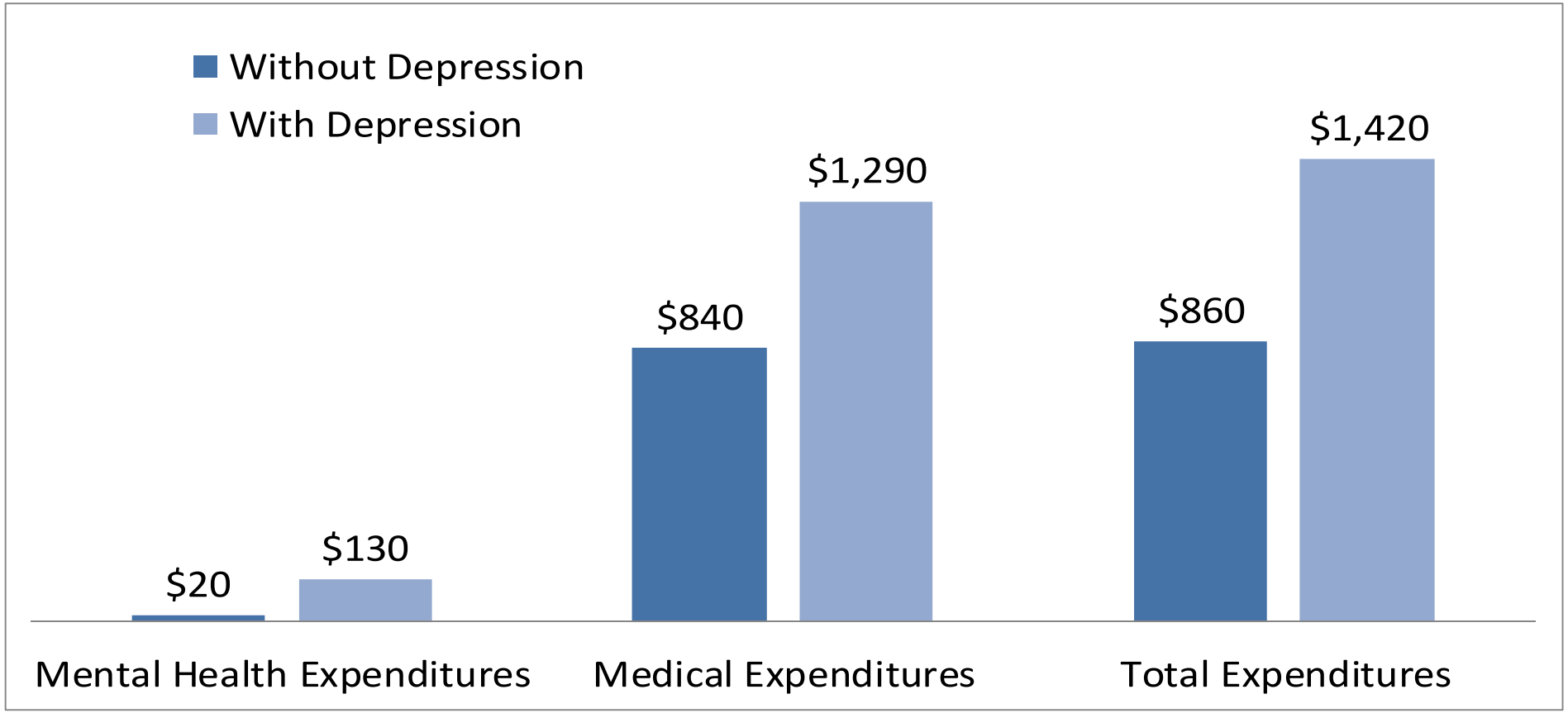
Adapted from Figure 2: Melek, S. P., Norris, D. T., & Paulus, J. (2014). Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Milliman America Psychiatric Assocation. Denver: Milliman Inc.

Monthly 2005 Health Expenditures per Person, for Chronic Conditions: Co Morbid Disorders Raise Costs



Team to Match Patient Population & Needs

Behavioral Health Providers	Diagnostic	Psychotherapy/ Counseling / Pharma	Brief Consultation w/ Patient	Brief Consultation w/ PCP	Health Behavior Consultation
Psychiatry (MD/DO)					
Psychology (PhD/PsyD)					
Social Work (MSW)					
APN- Psychiatry					
Health Coaches					

Summary:

- Behavioral Health Determinants
- Future Payment Models will focus on outcomes and quality
- To Improve Quality and Outcome, A need to focus on:

  Mental Health DX & TX
  Health Behavior

Our Mini-Summit Speakers:

Chris Hunter - DoD integration of health, mental health, health behaviors
Mike Peterson - the role of health coaches on an integrated team
Natalie Levkovich- the Health Federation of Philadelphia approach to integrated care
Tracy Bolander- plan to integrate primary care and behavioral health small practices

Integrated Behavioral Health Services in Primary Care

Christopher L. Hunter, Ph.D., ABPP
Department of Defense Program Manager for Behavioral Health in Primary Care

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DHA
Defense Health Agency

Overview

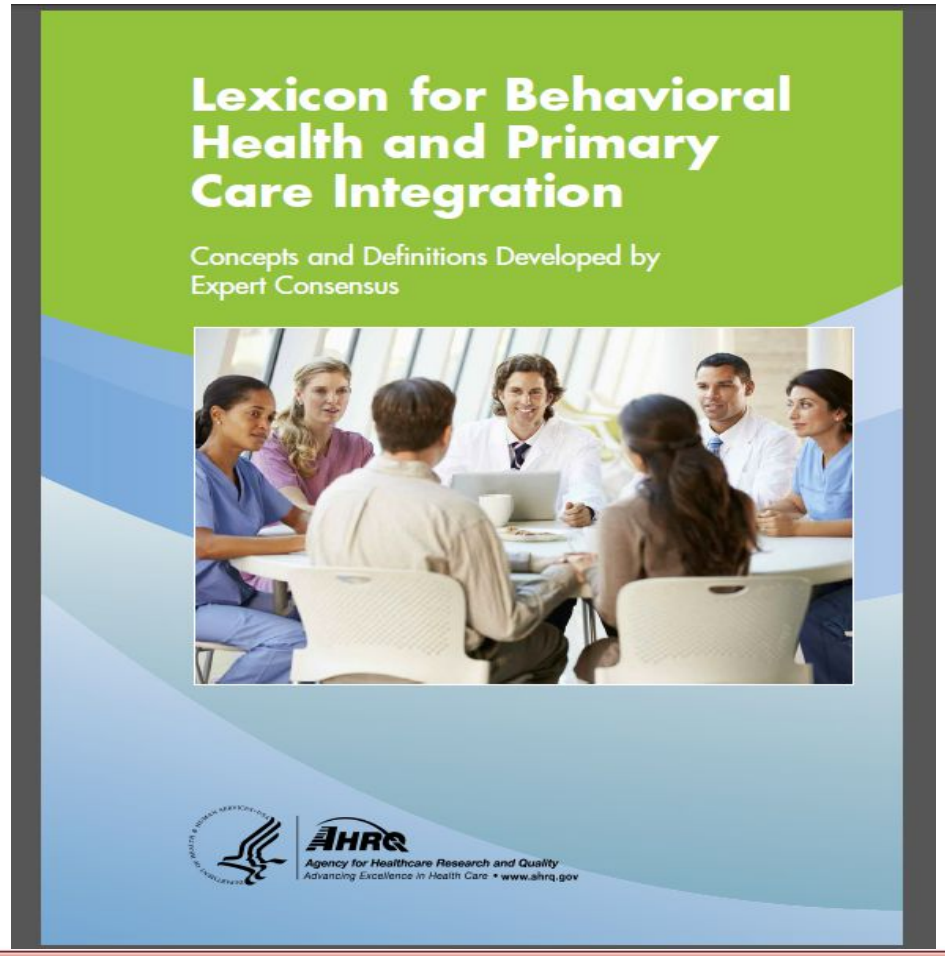
1. What is Integrated Care
2. Models of Integrated Care
3. Primary Care Behavioral Health Model
4. Clinical Pathways

Operationally Defining Terms

- **Integrated Care**: Umbrella term…range of service delivery *models*
- **Collaborative Care**: Umbrella term…how primary care managers (PCPs) & behavioral health providers *interact* to deliver services
- Confusion occurs when: "integrated care" or "collaborative care" is used to defined a specific model or component of a model of service delivery

Operationally Defining Terms

Integrated Behavioral Health Care…care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization (Peek, 2013, p. 2).



Commonly Used Models

Model	Practice Level	Third-Party Payment Ease	Services Included and Problems Treated	Caseload Size	Comments
Primary Care Behavioral Health	Provider	Fairly easy; state-by-state differences for treating general health conditions	• Behavioral Health (e.g., depression) • Substance Misuse (e.g., alcohol) • Health Behaviors (e.g., physical activity, eating behaviors, tobacco use, adherence to treatment) • Health Conditions (e.g., diabetes, chronic pain) Services include evidence-based intervention, education and self-management skills with patient	• Up to 16 pts day • Population with at least 3K patients	• Versatile model • Does not provide specialty level of care – only the primary level (i.e., helps patients self-manage their symptoms);
Collaborative Care (IMPACT Model)	Non-provider	More difficult; varies by state; nurse time may be paid by third party, but psychiatric prescriber's services are not; "shared care" delivered by psychiatrists are widely paid by third parties	• Telephonic medication mgmt • Monitoring and treatment adherence by nurse; • Any mental health problem for which medications are the first line treatment; • Part-time psychiatric prescriber serving a consultation and liaison function	• Population with at least 3K and • Typical caseload 80 patients; • If optimized and streamlined 150 to 300 may be possible	• Narrow model Organized around a specific disease; • Psychiatric prescribing advisor can be located outside the clinic when performing consultation and liaison role

Primary Care Behavioral Health Model

Focused on all enrolled patients

- Behavioral Health Consultant (BHC) is a primary care team member
- BHCs & PCPs share patient information
- BHC brings a team-based management approach
- Helps team improve BH assessment & intervention
- Sees patients in 15-30 minute appointments
- Same day as well as scheduled appointment availability
- Focuses on full range of patient health problem presentations
- Assist with shared medical appointments and educational classes
- Assist with clinical pathways

Different Than Specialty Behavioral Health

Dimension	BHC	Specialty BH Provider
Primary consumer	PCP	Patient/Client
Care context	Team-based	Autonomous
Accessibility	On-demand	Scheduled
Ownership of care	PCP	Therapist
Productivity	High	Low
Care intensity	Low	High
Problem scope	Wide	Narrow/Specialized
Termination of care	Pt progressing toward goals	Pt has met goals

Primary Care Behavioral Health Model (PCBH)

Qualitative review on 20 PCBH model service delivery studies showed significant improvements, generally with 4 or fewer 30-minute appointments on a range of problem presentations including:

- Insomnia, Obesity, Tobacco Use, Chronic Pain
- Depression, Anxiety, PTSD

Hunter, Funderburk, Polaha, Bauman, Goodie & Hunter (manuscript in preparation). Primary Care Behavioral Health Model (PCBH) Research: Current State of the Science and a Call to Action. Journal of Clinical Psychology in Medical Settings

Population Health

- Peterson, Raj and Lancaster (2014)[4]
  - Make the argument from a behavioral health perspective, that population health includes interventions and clinical applications focused on the entire patient population not individual patients.
  - They argue that less intensive interventions, delivered to all beneficiaries who might benefit, have the potential for greater impact on the overall population, than a more effective treatment for a smaller number of patients.
  - These interventions can be integrated into a set of standard operating procedures for clinical practice that involve administrative, nursing, primary care provider and behavioral health consultant staff.

Clinical Pathways

- Method of screening/assessment/intervention for a well-defined group
- States the goals and key elements of care
- Based on Evidence-Based Medicine guidelines, best practice and patient expectations by facilitating the communication, coordinating roles and sequences of multidisciplinary care team activities
- Goal is to improve quality of care, reduce risks, increase pt satisfaction and increase the efficiency in the use of resources

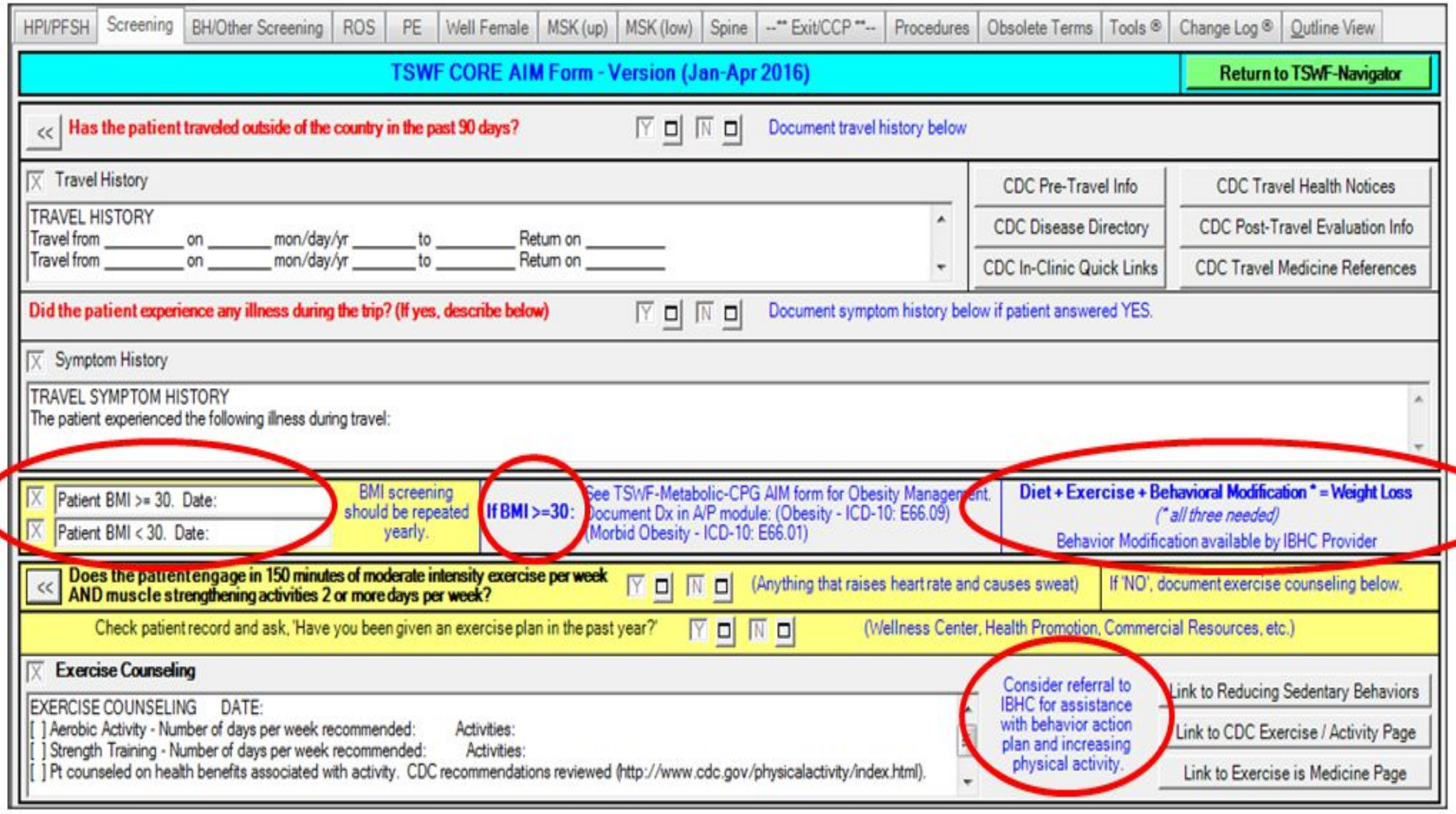
Clinical Pathways

- Designed to increase use of BHCs as part of standard care
- Designed to improve outcomes & patient & PCP satisfaction with care
- Pathways
  - Alcohol Misuse
  - Anxiety
  - Depression
  - Diabetes
  - Obesity
  - Chronic Pain
  - Sleep Problems
  - Tobacco Use

Clinical Systems/Processes

- Standard Clinical Operating Procedures
  - Screening/Assessment
    - Seamlessly woven into clinical care
    - Can be executed by staff other than the PCP
    - Valued added clinical data for PCP
  - Electronic Health Record
    - Easy documentation and clinical prompts
    - Data can be efficiently pushed/pulled electronically from the record

Obesity as an Example



Obesity as an Example

1. Identify patients for the pathway
2. Connect the patients to the pathway
3. Intervene in an evidence based way
4. Outcomes…is it working

Obesity as an Example

Identify

- HEDIS Measurement: Adult BMI assessment at every appointment
- Pull Care Point list of patients with: 1) BMI 30 or greater 2) diagnosis of overweight 3) diagnosis of obesity
- Patients with a BMI of 30 or greater at screening during PCP visit

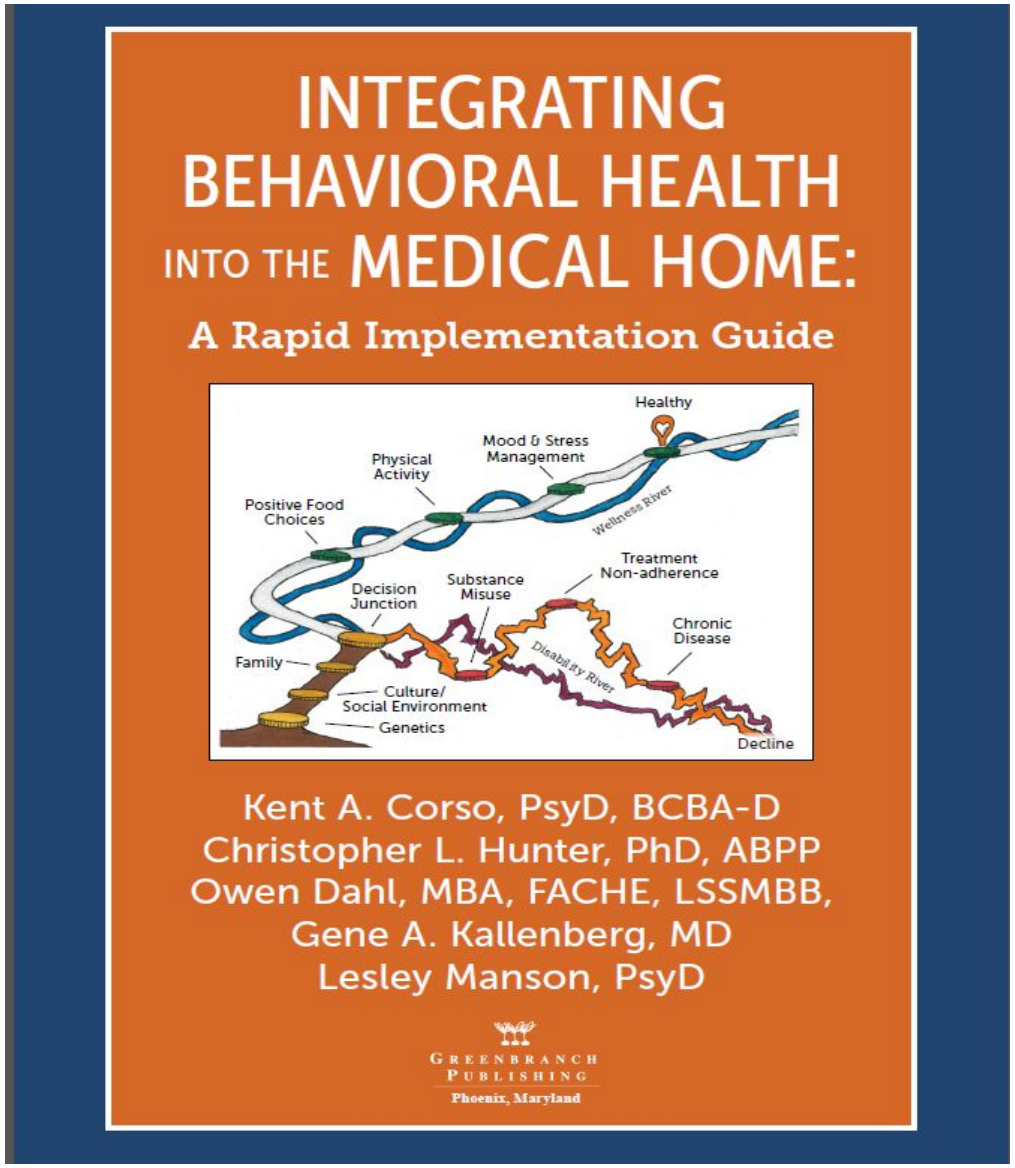
Connect

- During the visit, the PCP, nurse, or tech offers BHC visit
- The team (nurse or BHC) contacts the patients from HEDIS and/or Care Point list via telephone or secure messaging to offer a visit with BHC

Intervene

- BHC appointment (see Clinical Practice Guidelines)
- BHC will offer recommendations to the Medical Home team after the visit with the patient and start patient on an intervention change plan
- If patient declines the BHC visit, BHC should offer recommendations based on a review of the available electronic record.
- Possible referrals to nutrition, wellness, exercise specialist, occupational therapist, physical therapist etc. as indicated

Additional Resource



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****Christopher L. Hunter does not receive compensation for sales of this text.

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HEALTH COACHING

WHAT IS HEALTH COACHING?

- Health Coaching is a patient-friendly term for health behavior change assistance.
- Health Coaching professionals help clients with health change principles so that they are able to adhere to recommendations for personal health
- Health Coaching techniques and consultations focus on what patients can actively do to improve their health
- Health Coaches promote a patient's personal responsibility for their own health management

HEALTH COACHING CAN…

- HELP CLINICIANS GAIN MORE PATIENT INSIGHTS
- FOLLOW UP WITH PATIENTS POST-VISIT
- ENHANCE COMPLIANCE AND ADHERENCE
- FACILITATE POSITIVE BEHAVIOR CHANGES
- IMPROVE PATIENT HEALTH OUTCOMES
- EXTEND THE CLINICIANS REACH POST-VISIT
- PROVIDE A FUNCTIONAL APPROACH THAT COMPLEMENTS TRADITIONAL CARE

HEALTH COACHING TRAINING

- UNIVERSITY OF DELAWARE MODEL

- 18 GRADUATE CREDIT HOURS
- MUST HAVE A HEALTH RELATED UNDERGRADUATE DEGREE
- 120 CLINICAL HOURS
- STANDARDIZED PATIENT EXAM WITH REAL ACTORS
- DEVELOPED WITH PHYSICIANS, PSYCHOLOGISTS, BEHAVIORALISTS, NURSES, NUTRITIONISTS, PHARMACOLOGISTS
- PREPARED TO WORK IN A CLINICAL SETTING (HLPR 605)
- BEHAVIORAL ASSESSMENT, TRACKING AND INTERVENTION STRATEGIES
- MOTIVATIONAL INTERVIEWING & COACHING TECHNIQUES
- COMMUNICATION & RAPPORT BUILDING SKILLS
- REFERRAL KNOWLEDGE, PROFESSIONALISM, AND ETHICS
- KNOWLEDGE OF BEHAVIOR CHANGE MODELS, PROCESSES, AND HEALTHY BEHAVIORS

CURRENT HEALTH COACHING MODELS

- **HOW DO YOU WORK WITH A HEALTH COACH??**
- **For Clients:**
  - Individual One-on-One
  - On-site/Clinic
  - Telephonic
  - Group based sessions
- **For Clinics**
  - INDEPENDENT PROVIDER (REFERRAL)
  - CLINICAL TEAMETTE MODEL
  - PARTNER WITH CLINIC/PROVIDER

RESEARCH FINDINGS:

- Intervention: Health Coaching follow-up intervention in a primary care setting with patients with CV risks
- Study Design: Randomized Control Trial (patients followed 24 months from RCT baseline); HC arm N=224; Usual Care arm N=217
- 47.1% achieved primary goal at 12mo (vs. 35.7% in Usual care);
- 45.9% maintained at 24mo (vs. 33% in Usual care).
- CONCLUSION: health coaching may provide a cost-effective way to provide self-management support with effects that are largely sustainable over time.
- Reference: Sharma AE et al. (2016) What happens after health coaching? Observational study 1 year following a randomized controlled trial. Annals of Family Medicine. 14(3): May-June

RESEARCH FINDINGS

- 42% of primary care physicians report not having adequate time to spend with their patients. Bodenheimer & Pham (2010) Primary care: current problems and proposed solutions. Health Affairs. 29 (5) 799-805.
- Health coaches bridge communication gaps between clinicians and patients. Dube, Willard-Grace, O'Connel et al (2015) Clinician perspectives on working with health coaches. A mixed methods approach. Family Systems and Health. 33(3): 213-221.
- In random testing, after 12 months of health coaching, patients' trust in their primary care providers increased and their overall relationships were improved. http://creativecommons.org/licenses/by-nc-nd/3.0/
- Health coaches led to significant reductions in outpatient and total expenditures in high risk enrollees. Jonk, Lawson, O'Connor et al. (2015) How effective is health coaching in reducing health services expenditures? Medical Care. 53(2): 133-140.

HEALTH COACHING TESTIMONIALS

- “Health coaching has empowered me, and gave me what I needed to light the fire from within to believe in myself again! Health coaching was the accountability to stay on the path and keep going!” -Ann G.

- Simply having a follow-up phone call to voice whether I hit my goal motivated me to keep myself on track and self-reflect on my progress throughout the week. Because of health coaching, I now enjoy [exercise]– which I never thought I’d say – and I established new processes that will make my life easier, giving me what I need most as a working mom of 2…more quality time with my family.” -Amanda L.

TESTIMONIALS

- “I’ve had the benefit of working with a health coach for the last 10 weeks. I’m one of those people who has lost weight over the years on many different diets which just were not sustainable for me. I’d get off track and gain all the weight back, plus some. Talk about discouraging. I’m excited about the long-term approach that my health coach and I are taking to healthy living -- biting off little chunks at a time, seeing the results of meeting weekly goals, identifying and changing troublesome habits which have prevented me from experiencing success in the past, along with lots of encouragement. I’ve lost 13 pounds so far and have more energy. This is working for me and I’m grateful.” –Carol L.

- *(Carol is also now off all diabetic medication, has lost 13 pounds, maintains 12-15,000 steps per day and has added strength training to her weekly work-out schedule)*

TESTIMONIALS

- “I have always been overweight. After meeting with (MY HEALTH COACH) almost three months ago, I started setting goals. Some as small as changing my menu just twice a week to long terms goal like running a 5k.
- When I started, I weighed 324lbs and could not jog for 1 minute without stopping. Today I am down 20lbs and this past Saturday (three-month goal) I just completed my first 5k ever.” -Dan S.
- *(Dan now walks to work each day, rain or shine (1/2 miles each way) and accumulates nearly 20,000 steps per day. He has changed many of his health behaviors including eating habits (when and where) and food choices (this, not that). After the 5k, his family decided to sign up for the next 5k as a team. I ran the 5k by his side and 5 of his co-workers showed up as well. It was a wonderful moment in time).*

HEALTH COACHING AND INTEGRATIVE HEALTH CARE @ UD

- UD HEALTH COACHING CLINIC
- GROUP BASED COACHING
- ON-SITE INTEGRATIVE SUPPORT
- CURRENT OUTREACH
  - "ALL ABOUT WOMEN" PROGRAM AT CCHS
  - ONCOLOGY
  - PEDIATRIC MEDICINE
  - WORKSITES
  - DIABETES

IMPORTANT POINTS TO CONSIDER

- NOT ALL HEALTH COACHES ARE CREATED EQUAL
  - STILL THE WILD WEST
- NATIONAL STANDARDS SET BY NATIONAL CONSORTIUM FOR CREDENTIALING HEALTH AND WELLNESS COACHES (NCCHWC)
- MEDICAL BOARD OF EXAMINERS WILL ADMINISTER HEALTH COACHING CERTIFICATION EXAMS
- STILL WORKING ON ACCREDITATION OF PROGRAMS
- 3RD PARTY REIMBURSEMENT STILL NOT ESTABLISHED

HEALTH FEDERATION
OF PHILADELPHIA
The keystone of community health since 1983

Philadelphia Integrated Care Network: Regional Implementation of Primary Care Behavioral Health

Natalie Levkovich

- *Chief Executive Officer, Health Federation of Philadelphia*
- *2016 President, Collaborative Family Healthcare Association*

About the Health Federation of Philadelphia

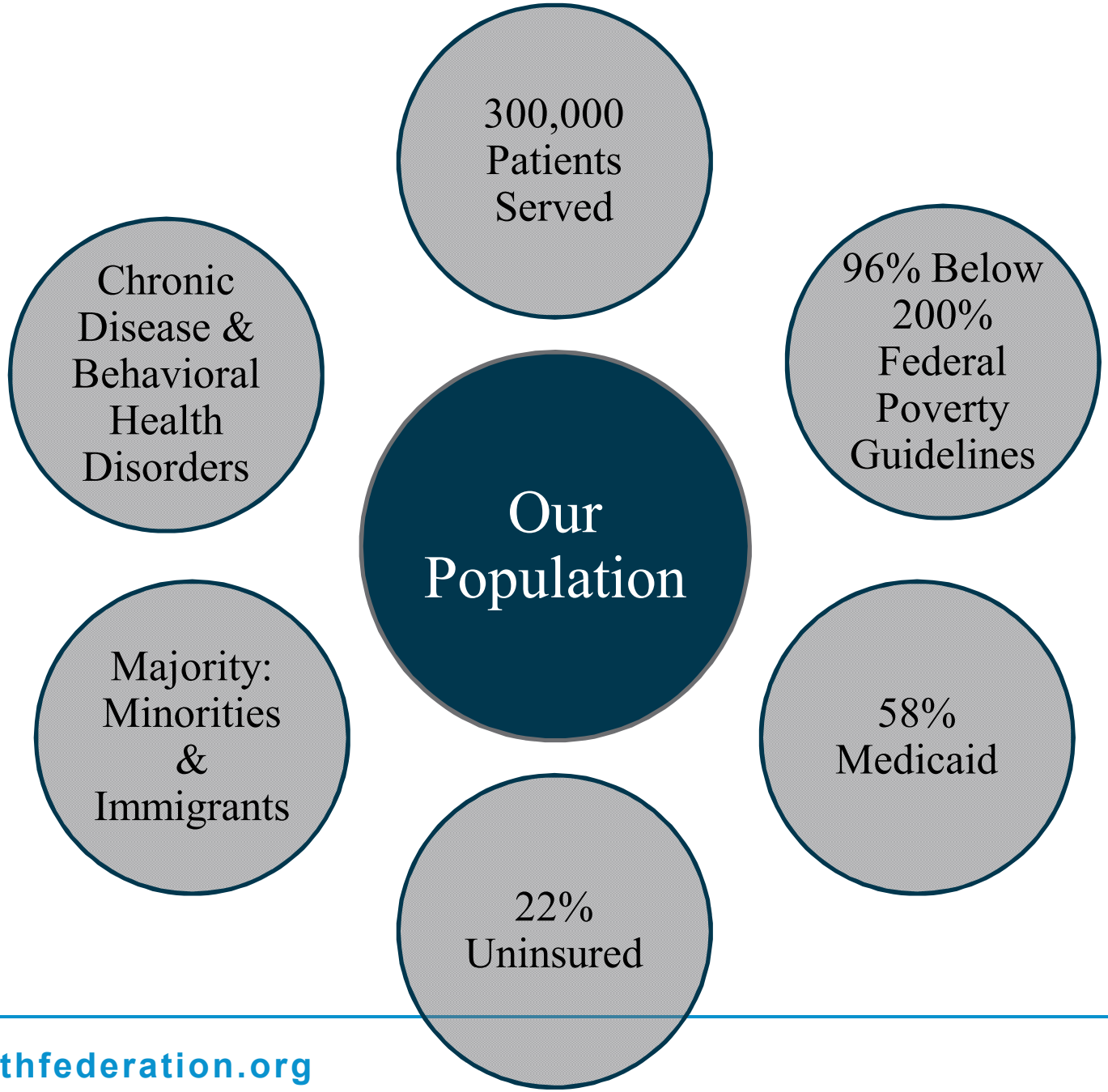
Our Mission

The mission of the Health Federation of Philadelphia is to improve access to and quality of health and human services for underserved and vulnerable populations

Our History

- Nonprofit public health organization
- Established 1983
- Consortium of community health centers

COMMUNITY HEALTH CENTER FQHC QUALITY SM


300,000 Patients Served
Chronic Disease & Behavioral Health Disorders
96% Below 200% Federal Poverty Guidelines
Our Population
Majority: Minorities & Immigrants
58% Medicaid
22% Uninsured

Reasons to Integrate Care

Problem:

Behavioral health challenges result in:

Higher annual health care costs

Reduced capacity for self-management

Increased provider frustration

Less success partnering with medical providers

Solution

- An efficient approach that includes having behavioral health professionals embedded in primary care

Meeting Needs

- Address behavioral issues frequently encountered among patients
- Increase access to behavioral health services
- Create a feasible model that recognizes the mission, operational capacity, and business requirements of community health centers

Our Process

History & Development

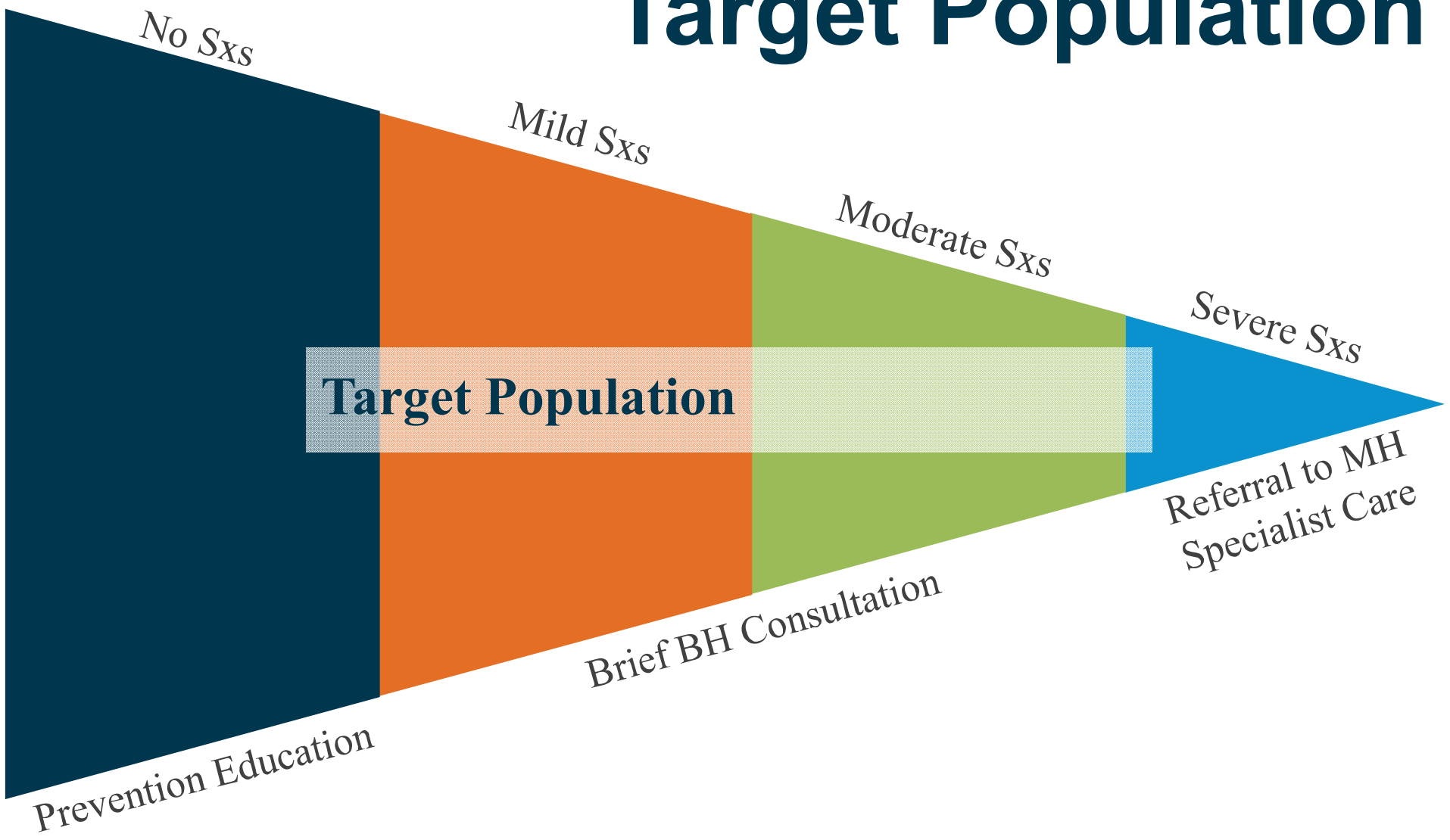
- Co-located behavioral health at different sites
- Collaborated to develop better plan
- Worked with health centers, payer, and consultants
- Incrementally adopted PCBH
- Created Philadelphia Integrated Care Network (PICN)

Our Model:

Based on the Strasahl & Robinson model

- Behavioral Health Consultation
- Team Work
- Population-Based Focus
- Immediate Access
- Evidence-Based Interventions
- Solution-Focused Approach
- Functional Restoration

Target Population



Implementation & Core Activities

Implementation Challenges

One Site Readiness	**Two** Implementation Support	**Three** Availability of Qualified Workforce	**Four** Sustaining and Improving Practice
Five Adopting Population Focus	**Six** Maintaining Model Fidelity	**Seven** Replication & Spread	**Eight** Other Challenges

Implementation Strategies

Advocacy: Worked with Medicaid MCO

- To understand primary care priorities, operations, population
- To approve clinical model
- To modify credentialing and payment methodology
- To institutionalize the relationship

Implementation Strategies

- Developed practice-based training approach
- Established regional community of practice for support
- Adapted technical assistance strategies to support replication
- Added novel methods to promote model fidelity
- Persistence

Core Activities

Site Support

- Site Orientation
- Self-assessment
- Clear Role Definitions & Policies
- Manual
- Provider Orientation
- Follow Up Debriefing/Technical Assistance

Core Activities

BHC Support

- BHC Recruitment
- Initial Orientation
- Shadowing/ Coaching
- Boot Camp
- Ongoing Professional Development

BH Supervisor Support

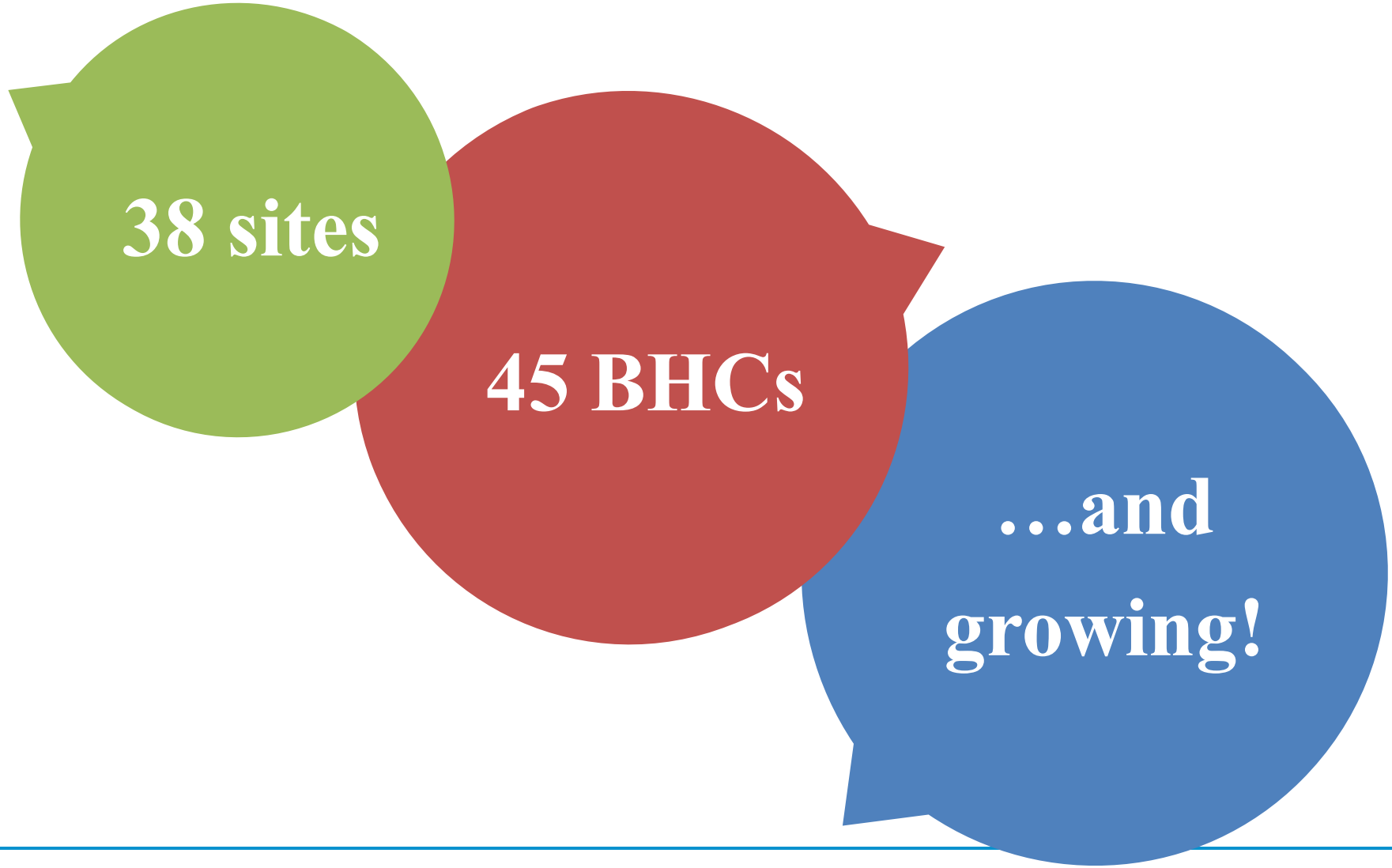
- Regular program development meetings
- Training in BHC core competency rating

Core Activities

Community of Practice

- Peer Support
- Shared Resources/Shared Problem Solving
- Professional Identity
- Leadership Development
- Collective Advocacy

Building a Network



The Health Federation of Philadelphia
is continually developing new programs in response
to both the needs of underserved communities and the
availability of data indicating improved approaches
to health care and behavioral support.

For more information about our initiatives, please visit:

www.healthfederation.org

Delaware Center for Health Innovation

Statewide Approach to Behavioral Health Integration – Delaware's perspective

Traci Bolander, PsyD
Licensed Psychologist, Mid-Atlantic Behavioral Health,LLC
DCHI Board member, Payment Committee co-Chair, Clinical Committee member

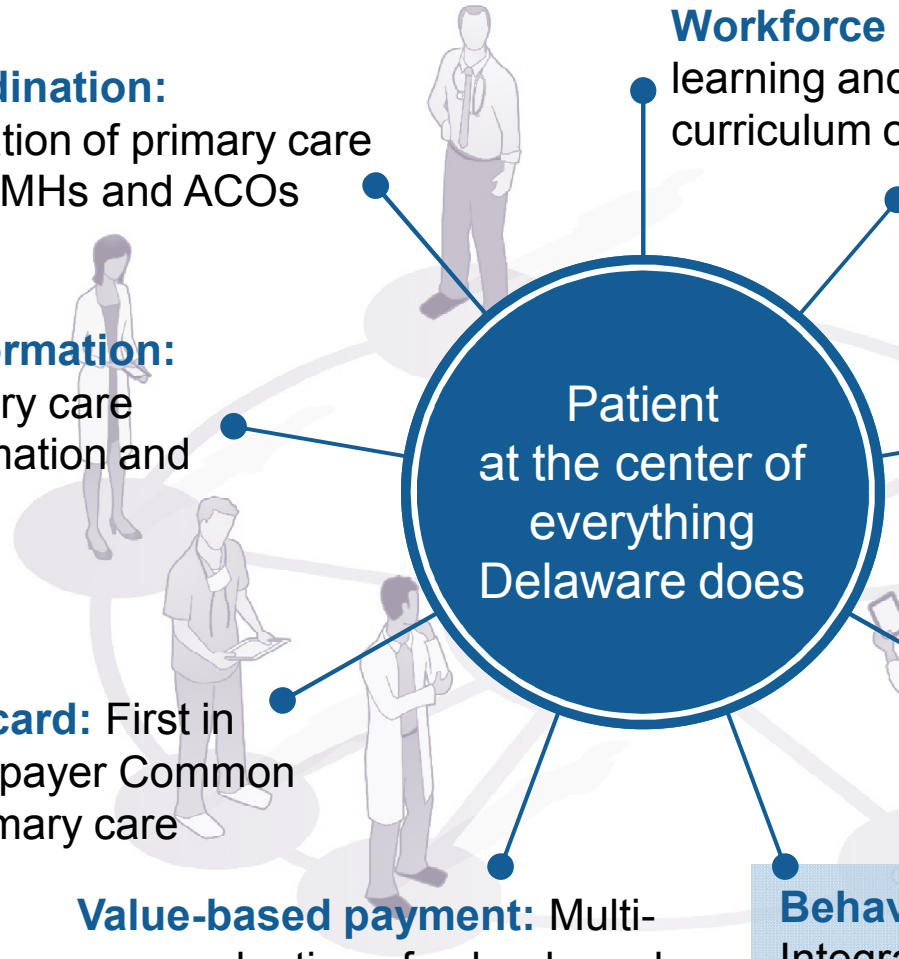
December 2, 2016

Delaware's SIM initiative: where we are today

- In 2013, the Delaware Health Care Commission convened stakeholders across the state to build a strategy that would **improve each element of the Triple Aim**: better health, improved healthcare quality and patient experience, and lower growth in healthcare costs
- This resulted in obtaining a CMMI SIM grant which helped establish the **Delaware Center for Health Innovation (DCHI)** a consensus-driven multi-stakeholder organization formed to ensure successful implementation of Delaware's strategy
  - Public/private partnership with diverse representation across the state
  - Consensus-based approach with input from broad set of stakeholders
- DCHI has **ambitious goals** for the SIM effort
  - One of five healthiest states
  - Top five state in healthcare quality and patient experience
  - Bring healthcare cost growth in line with GDP
- Due to the large number of primary care practices in Delaware and high percentage of self-insured plans, DCHI's has heavily focused its initiatives (e.g., Practice Transformation, value-based payment expansion, Common Scorecard) on **primary care practices**
- DCHI is now focusing on another important area for primary care practices, **integration of behavioral health services**

Behavioral Health Integration (BHI) is a key component of Delaware's patient-centered strategy

Focus for today



Care coordination: Transformation of primary care through PCMHs and ACOs

Workforce Curriculum: Innovative two-year learning and development program with common curriculum on team-based, integrated care

Healthy Neighborhoods: Scorecard, tools, data, and resources to support neighborhoods

Practice Transformation: Support for primary care practice transformation and care coordination

Community-based health: Integration of community-based health initiatives with delivery system focused on priority health needs

Common Scorecard: First in the country multi-payer Common Scorecard for primary care

Adoption: Medicaid MCO RFP, state employees, and QHP standards to drive adoption

Value-based payment: Multi-payer adoption of value-based payment on statewide basis

Behavioral health integration: Integrating behavioral health services into primary care

Behavioral Health Integration

Why is behavioral health integration important?	▪ ~15-30% of the U.S. population currently have a behavioral health diagnosis ▪ ~70% of adults with behavioral health conditions also have medical conditions ▪ Uncoordinated treatment of behavioral health and primary care conditions leads to poor outcomes and increased costs
Why is behavioral health integration challenging?	▪ Operational and structural barriers ▪ Uncertainty around economic sustainability for practices and patient affordability ▪ Lack of access to behavioral health providers ▪ Lack of training on working in integrated teams
What support is available in Delaware?	▪ **HCC[1]'s EMR incentive program** is open for applications and improves broad connectivity between behavioral health providers and primary care physicians ▪ **DCHI's Behavioral Health Integration testing program** is forthcoming and provides support for practices integrating behavioral health into primary care

1 HCC: Delaware's Health Care Commission

Small practices in Delaware experience several barriers to Behavioral Health Integration

Align reimbursement environment

- Varied medical policies and reimbursement practices across payers increases confusion
- BH services billed by PCPs may require extra legwork to get reimbursed, even when covered under policy
- Higher volumes of referrals required to compensate for higher rate 1st time no-shows

Identify partner(s)

- Potential lack of urgency among PCPs
- No facilitated channel to connect BHPs and PCPs interested in integration
- Shortage of BHPs could make partnership more difficult
- Smaller PCPs' panel size may not merit full-time BHP

Develop operational processes

- BHI requires addressing e.g., workflows, office space, billing systems, medical records
- Supportive services exist to address above issues, but securing support and coordinating across issues may be challenging for small practices

Formalize partnership

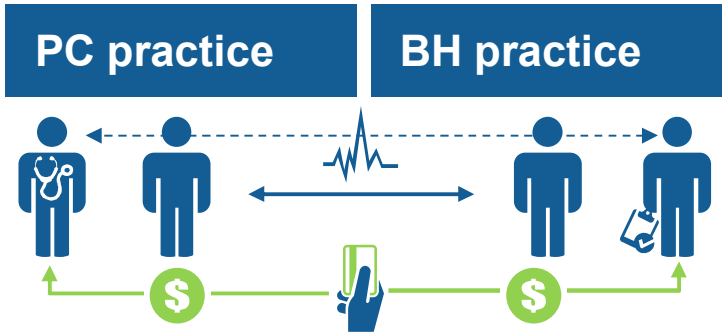
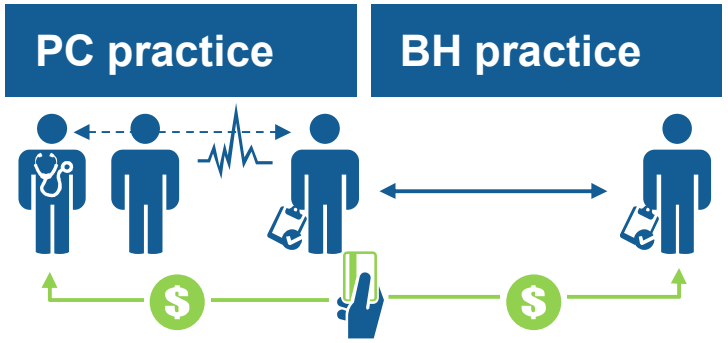
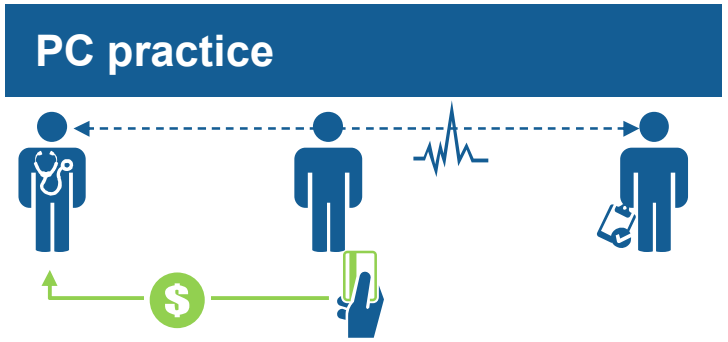
- Limited awareness of partnership models and steps needed to formalize (e.g., PCP contracts for block of BH provider time or PCP pays per patient)
- PC and BH practices may have cultural barriers that make formal integration challenging

Small practices, in particular, find it difficult to identify partners and make up-front investments (e.g., modify schedules/workflows, contract for BH services), especially when reimbursements are uncertain

Three models are being employed in DE to overcome BHI challenges

PROPOSED AND PRELIMINARY

Patient | PCP | BHP | Relocation | Payer | Billing | Patient data

	Description of model	Challenges addressed	Depiction of model
1 Referral and co-management	▪ PC practice establishes referral relationship with behavioral health practice; each practice bills separately	▪ Identify partners ▪ Develop operational processes	
2 BH provider co-located but bills separately	▪ PC and BH practices coordinate co-location of behavioral health providers; each practice bills separately	▪ Identify partners ▪ Formalize partnerships ▪ Develop operational processes	
3 Employed / contracted BH staff	▪ PC practice employs/ contracts BHPs; PC practice bills for all services	▪ Align reimbursement environment ▪ Identify partners ▪ Formalize partnerships ▪ Develop operational processes	

PC: Primary care; BH: Behavioral Health; PCP; Primary Care Physician; BHP: Behavioral Health Provider

Participating practices will be supported with several resources to assist with successfully implementing BHI

Why BHI matters to providers

- Opportunity to become an **early adopter of BHI,** which has had success in DE and will be a component of new **value-based payment models**
- Opportunity to **improve outcomes and decrease costs** for patients through coordinated care

Available support for participating practices

Expert training on integration of behavioral health into primary care, for practice clinicians and staff, through a certified training vendor

Access to **dedicated group of BHI experts** to provide **operational support** related to integration (e.g., workflows, scheduling, billing)

Partnership with primary care practice for referral/ contract/ employment to provide new BH services for populations with need

Data and reporting to assist with tracking effectiveness of behavioral health integration

Financial support for startup costs incurred with implementing BHI at practice[1]

1 Dependent on availability of funds

What we have learned in Delaware

- Primary care practices (especially small-medium sized practices) are often overworked and understaffed; important to **make value proposition clear to practices** that may see integration as an additional burden
  - **Connect behavioral health integration with other value-based initiatives** occurring in the state (e.g., value-based payment models, practice transformation efforts)
  - Assist practices with **building their business case** using economic models
  - Utilize **case studies/testimonials** from practices in the state who have seen operational/financial benefits from BHI
- Important to **engage major payers early**; we learned that reimbursement challenges were often perceptions or implementation of policy, rather than payer policy itself
- While funding behavioral health integration in practices may be challenging, **several funding sources exist** (e.g., national grants, foundations, state Medicaid, commercial payers)
- States that wish to use CMMI funding to support pilots may need to focus on funding **infrastructure costs and vendor support** rather than provision of services

DCHI's practice transformation initiatives

Description	Contact
Practice Transformation ▪ Clinical and operational change program designed to help you care for all of your patients effectively/ prepare for value-based-payment models ▪ **How do I enroll?**	▪ Research and contact one of our four vendors ▪ **http://www.choosehealthde.com/Providers/Practice-Transformation**
Common Scorecard ▪ Single, integrated scorecard across all payers that measures performance on quality, utilization, and cost across all of your individual patients ▪ **How do I get access?**	▪ Contact the Delaware Health Information Network ▪ **http://www.choosehealthde.com/Providers/Common-Scorecard**
EMR incentive ▪ Funding for behavioral health providers seeking to adopt or upgrade EMRs ▪ **How can I apply?**	▪ Respond to RFP – **http://bids.delaware.gov/bids_detail.asp?i=4011&DOT=N**
Behavioral Health Integration Testing Program ▪ Program to provide practices with the support, resources, and expertise necessary to integrate behavioral health services into primary care ▪ **How can I keep abreast of forthcoming updates?**	▪ Contact DCHI ▪ **http://www.choosehealthde.com/Providers#intro**

All links are accessible through the DCHI website. For general questions visit **http://www.choosehealthde.com** or email: **info@dehealthinnovation.org**

QUESTIONS?

American Psychological Association