Behavioral Health Bootcamp

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Consultant
National Council for Mental Wellbeing

Today's Presenter

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About the National Council

Founded in 1969, the National Council for Mental Wellbeing is a national membership organization that drives policy and social change on behalf of nearly 3,500 mental health and substance use treatment organizations and the more than 10 million children, adults and families they serve.

- **Our Vision:** To make mental wellbeing, including recovery from substance use challenges, a reality for everyone.

- **Our Problem Statement:** Despite overwhelming need, nearly 30 million people across the U.S. don't have access to comprehensive, high-quality, affordable mental health and substance use care when they need it.

- **Our Solution Statement:** By promoting mental health, recovery from substance use challenges and equitable access to high-quality care, we will ensure that mental wellbeing is a reality for everyone.

NATIONAL COUNCIL *for* Mental Wellbeing


Moment to Arrive

Introductions

Please share your name, any preferred pronouns, title, organization, and location

AND

What is something you like to do during your workday, or

what brings you joy/satisfaction in your work?

Our Time Together

- 11:30 am – 12:30 PM
  - Key Issues and Priorities in Behavioral Health Policy and Practice
- 12:30 PM – 1:15 PM
  - Lunch Break
- 1:15 PM – 2:30 PM
  - Deeper Dive: Models of Care and Integration
- 2:30 PM – 4:00 PM
  - Brief Break
  - Addressing the Workforce Crisis and Skill building
- 4:00 PM – 5:30 PM
  - Brief Break
  - Open forum and Discussion

Key Issues and Priorities in Behavioral Health Policy and Practice

Subsession 1

11:30 – 12:30pm

Public Policy Mission Statement

National Council for Mental Wellbeing advocates for assertive public policies that:

- Ensures equitable access to high-quality services;
- Builds the capacity of mental health and substance use treatment organizations; and
- Promotes a greater understanding of mental wellbeing as a core component of comprehensive health and health care.

Strengthen the mental health and substance use workforce

Workforce Shortages and Increased Demand

- Demand for services continues to increase
- Challenges with recruitment and retention
- Waitlists are growing
- Funding and attention to administrative burdens are needed

Staff Burnout

Staffing Shortages

Qualified Staff

COVID-19 Burnout

Client Needs

Adequate Staff Training

https://www.thenationalcouncil.org/wp-content/uploads/2022/04/NCMW-Member-Survey-Analysis-September-2021_update.pdf

Developing and Supporting the Workforce

Recruitment and Retention

- Financial incentives
- Tuition reimbursement
- Clinical supervision
- Professional growth
- Internships
- Mentoring
- National Health Service Corps
- Team-based collaboration
- Flexible scheduling
- Telehealth

Bolster substance use prevention, care, and recovery

Opportunities to impact substance use disorders

1. In a screening study in three primary care clinics providing care for more than 14,000 patients annually, 23% of the participants had a current SU disorder.
2. As many as **five out of six patients** who meet diagnostic criteria for alcohol use disorder go unrecognized in primary care settings
3. 10% of the people with a substance use disorder get treatment

1. Brown Rl, Leonard T, Saunders LA, Papasouliotis O. A two item conjoint screen for alcohol and other drug problems. The Journal of the American board of Family Practice. March/April 2001. Vol 14 No. 2: 95-106
2. http://www.integration.samhsa.gov/about-us/esolutions-newsletter/integrating-substance-abuse-and-primary-care-services
3. https://www.samhsa.gov/data/sites/default/files/nsduh-ppt-09-2018.pdf

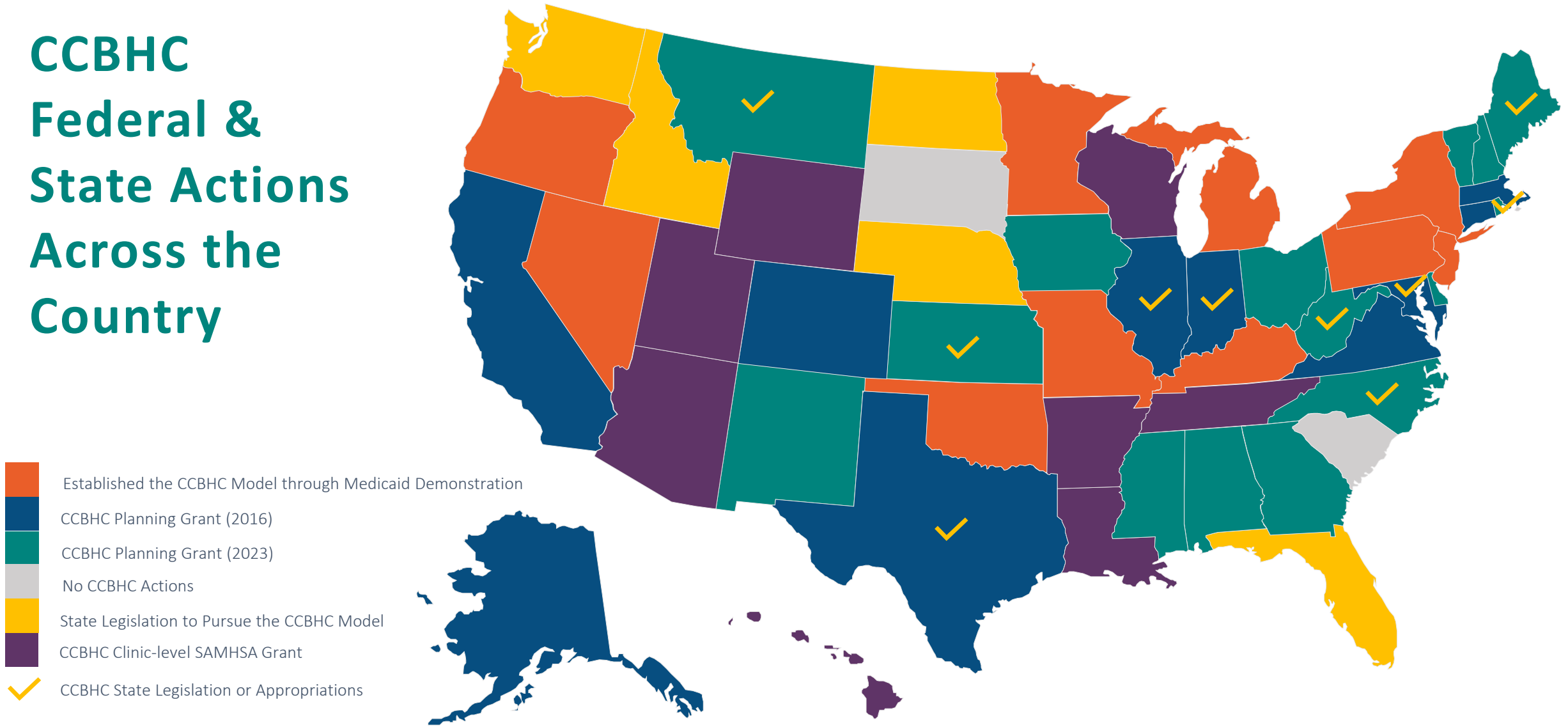
Protect and grow funding

Increase equitable access to high-quality services

Certified Community Behavioral Health Clinics (CCBHCs)

- CCBHC 2.0 legislation aims to establish sustainable structures for funding and operating CCBHCs by
  - Authorizing the SAMHSA CCBHC-E Expansion Grants
  - Authorizing the CCBHC TA Center
  - Creating a CCBHC Data Infrastructure Program
  - Creating CCBHC as a Provider Type in Medicaid and Medicare

CCBHC Federal & State Actions Across the Country



Virginia Community Healthcare Association Annual Meeting and Conference
September 27–29

CCBHC Funding Opportunities

CCBHC Options via Medicaid

Medicaid Waiver (e.g., 1115)	State Plan Amendment	CCBHC Demonstration
Enables states to experiment with delivery system reforms	Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.	Enables states to experiment with delivery system reforms
Requires budget neutrality	Does not require budget neutrality	Does not require budget neutrality and provides an enhanced FMAP for states
Must be renewed every 5 years	With CMS approval, can continue PPS	For only 10 states every 2 years in 2024
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)	Cannot waive "state-wideness," may have to certify additional CCBHCs (future CCBHCs may be phased in)	State may limit the number of clinics selected to receive the PPS rate
With CMS approval, offers opportunity to continue or establish PPS		State must be sure to follow all CCBHC criteria with ability to build onto them

CCBHC Grants

CCBHC Grants (SAMHSA funds)
$4 million available for a 4-year period; Previously for a 2-year term
Grants are given directly to clinics with self-attestation that they meet CCBHC criteria.
Clinics provide all CCBHC services and activities of a CCBHC as required by SAMHSA, including basic reporting requirements.
Grant funds supplement but do not supplant other coverage sources

400+ CCBHC grantees
500+ in total to date

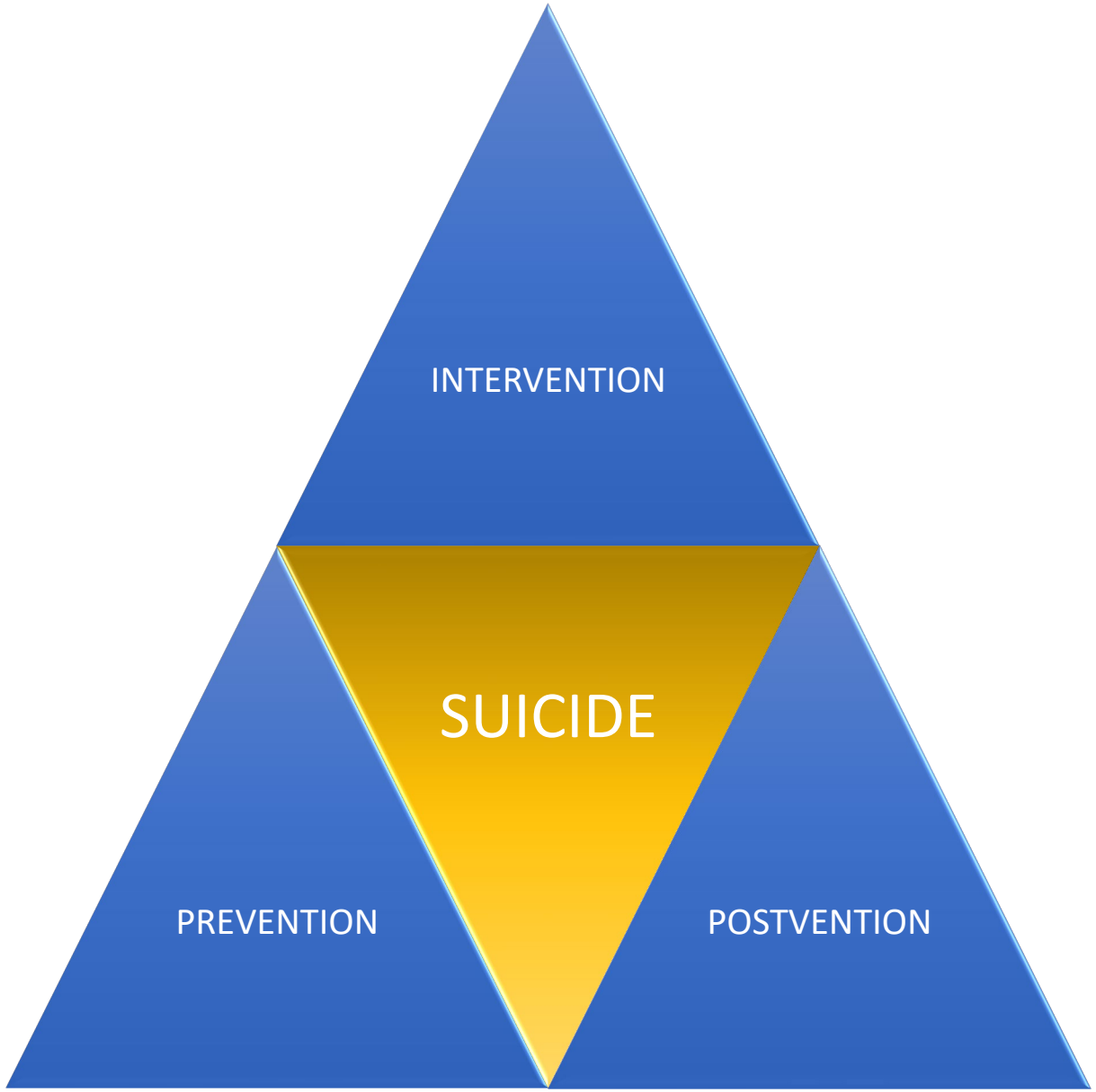
CCBHC Partnership Opportunities for FQHCs

- Two types of partnerships with CCBHCs:
- 1. Care Coordination Relationships
- 2. Formal Relationships with Designated Collaborating Organizations

Community partnerships are integral to the vision of holistic, person-centered care embodied by the CCBHC demonstration.

Promote comprehensive 988 implementation

SUICIDE


INTERVENTION
SUICIDE
PREVENTION
POSTVENTION

Elevate initiatives impacting justice-involved populations

Support mental health and substance use parity

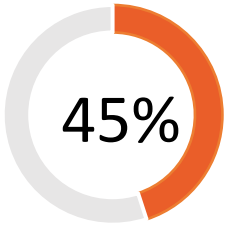
Expand access to telehealth mental health and substance use services provided

Support youth and maternal mental health and substance use prevention and treatment

Sounding the Alarm on Youth Mental Health

- In 2021:
  - **more than 4 in 10 students** felt persistently sad or hopeless and nearly one-third experienced poor mental health.
  - **more than 1 in 5 students** seriously considered attempting suicide and 1 in 10 attempted suicide.

> These feelings were found to be more common among LGBQ+ students, female students, and students across racial and ethnic groups.



of LGBQ+ students in 2021 seriously considered attempting suicide—far more than heterosexual students.

Black and African American students were more likely to attempt suicide than students of other races and ethnicities.

CDC Youth Risk Behavior Survey, 2011-2021.

Even if we identify…

- Less than 20% of children who meet diagnostic criteria for psychiatric disorder are referred to behavioral health services
- Specialty substance use treatment for adolescents can be very effective, **but less than 10%** of youth in need of treatment ever receive it.
  - Part of the reason is that few adolescents are referred to treatment by their ***health care providers*** (SAMHSA NSDUH 2015; SAMHSA MH Estimates 2014).

Implementing Services In Schools

- Unique to the setting, needs and resources
- Iterative learning process – trial, error, and lessons on the ground

- Strategies for Success

Messaging and Promotion

to promote school-based health care services to the school community

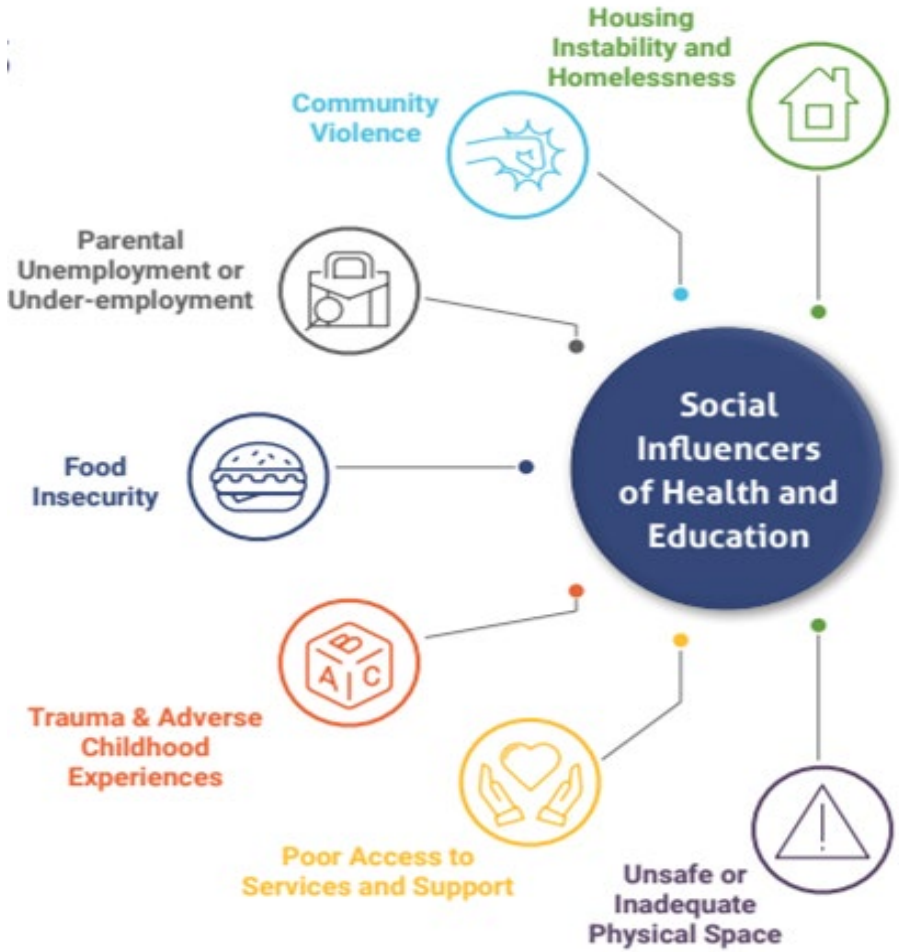
Continuous Planning and Quality Improvement

including regular convening of community partner, school and stakeholders

Engaging Youth Voice

via e.g., advisory council

Social Influencers of Health and Education



Social Influencers of health such as poverty, **unequal access to health care**, lack of education, stigma, and racism are underlying, **contributing factors of health inequities.**

For youth, these outcomes are often experienced **disproportionately by race and ethnicity** and contribute to health inequities, learning disruptions, and opportunity gaps.

National Center for School Mental Health, Understanding Social Influencers of Health and Education, 2020.

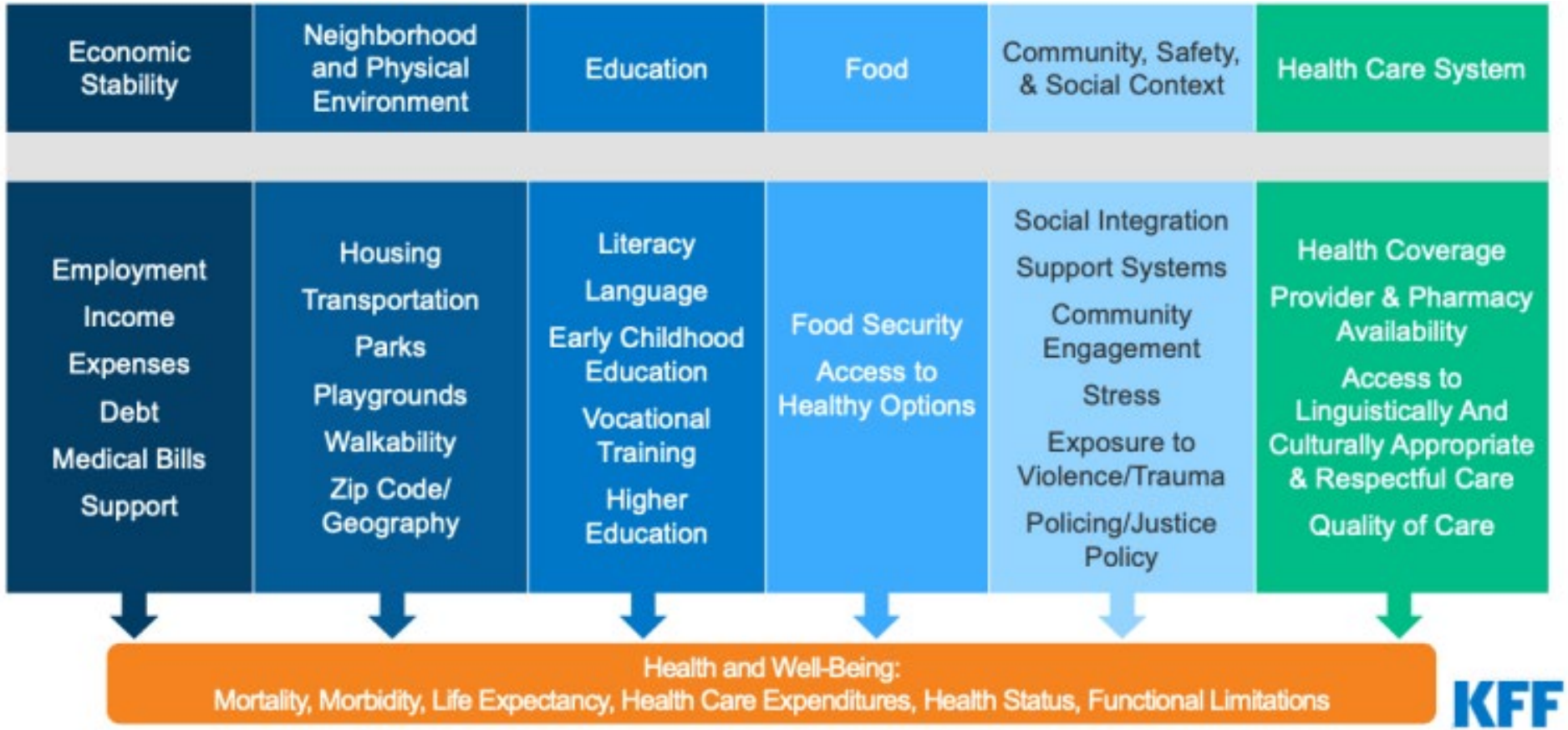
Seeing more initiatives, like Montana's…

The Meadowlark Initiative®

HEALTHY PREGNANCIES & SECURE FAMILIES

Address social determinants of health

Social Determinants of Health



Source: https://www.who.int/teams/social-determinants-of-health, Retrieved on 2/21/2023
Source: https://www.kff.org/coronavirus-covid-19/issue-brief/tracking-social-determinants-of-health-during-the-covid-19-pandemic/ Retrieved on 2/21/2023

Social Conditions as Fundamental Causes of Disease

Too much focus on individual risk factors. **More attention should be paid to social conditions/person in context.**

Two reasons for this claim:

1) Individually-based risk factors must be contextualized,
2) Social factors such as socioeconomic status and social support are likely fundamental causes of disease that, b/c they embody access to important resources, affect multiple disease outcomes.

Source: Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. Journal of health and social behavior, 80-94.

The Behavioral Health Landscape

- 350 individuals for every one
- 1 in 10 youth.
- 60% of youth
- 43% of US adults

Behavioral Health Workforce

Access to Care

90%

are concerned about the ability of those not currently receiving care to gain access to care

87%

worry that shortages in the mental health and substance use treatment workforce will negatively impact society as a whole

Mental Health America, State of Mental Health Report, 2023.
The Harris Poll, Mental Health: A comprehensive look at Harris Poll research, 2023.

Mental Health within Primary Care

- More than a **quarter of adults** with physical health problems also suffer from mental illness
- 25% of primary care patients have depression or anxiety
- Patients with mental illness frequently present to primary care with physical health symptoms (e.g., fatigue, insomnia, palpitations)

http://www.hbs.edu/faculty/Publication%20Files/2012.02.29%20Value-Based%20Mental%20Health%20Delivery_db29fc61-98a3-421d-a734-2c46d2989c73.pdf#sthash.v3JvdBGX.dpuf

Primary Care Settings

High prevalence of a range of behavioral health conditions

- Anxiety
- Depression
- Substance use in adults
- Anxiety
- ADHD
- Behavioral problems in children

(Prevention and early intervention opportunity)

People with common medical disorders have high rates of co-morbid behavioral health conditions

- Diabetes
- Heart disease
- Obesity
- Asthma

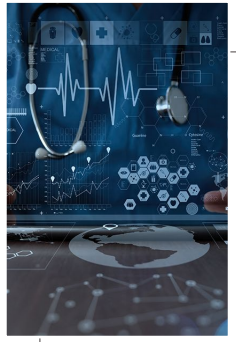
(Worse outcomes and higher costs if <u>both</u> problems aren't addressed)

- **Depression is the 3rd most common reason for a visit to a health center after diabetes and hypertension**

Areas of Focus & Priority Topics

Implementing Models of Integrated Care

Health Equity



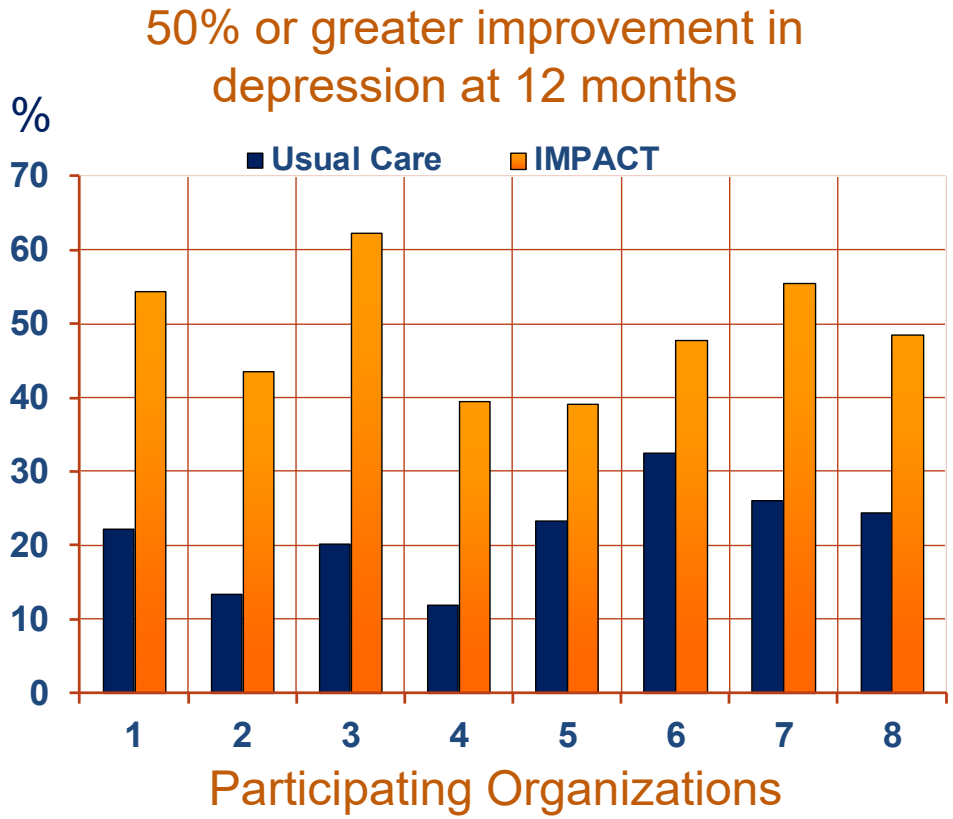
Population Health in Integrated Care

Integrated Care Operations

Diversity, Equity, Inclusion, Belonging & Impacts of COVID-19 Pandemic

Integrated Behavioral Healthcare Models Work!

- Increase our access to patients
- Provide more EBP to our communities
- More effective
- Reduces stigma
- Client-centered – the patient's treatment plan



Unützer et al., JAMA 2002; Psych Clin NA 2004

And…Patients Like Integrated Care Approaches!

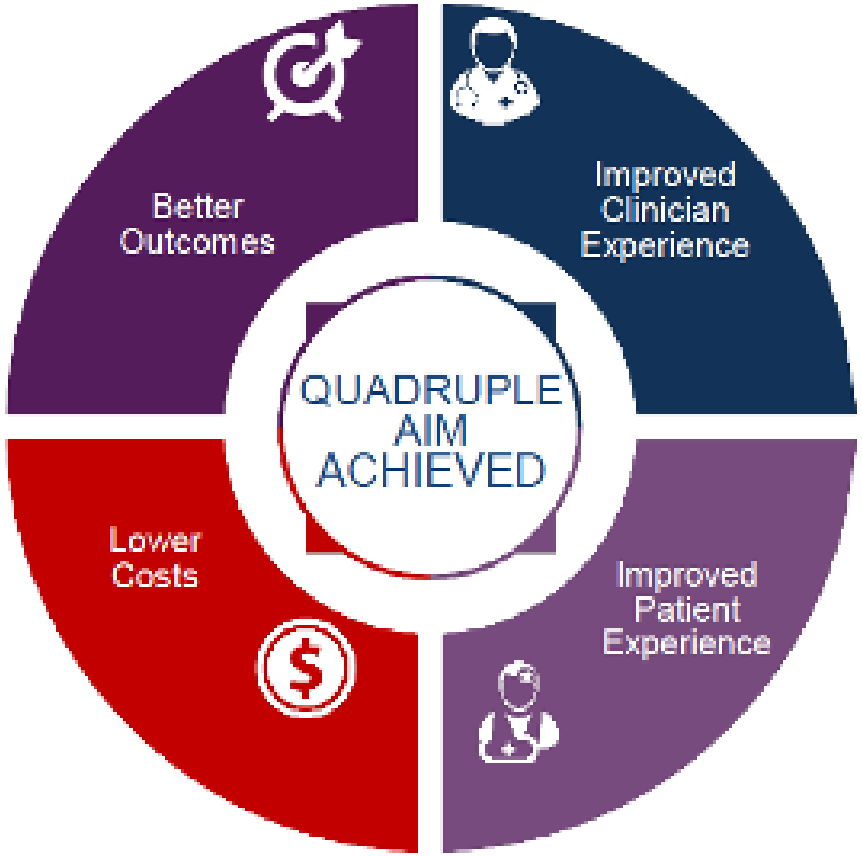
- For example, older adults reported greater satisfaction with mental health services integrated in primary care settings than through enhanced referrals to specialty mental health and substance abuse clinics.
- Patient engagement helps to drive health literacy and ultimately patient "ownership"/responsibility for health behavior change.
- In the new marketplace the patient has more choice about who to see so customer satisfaction matters…

Source: Chen H, Coakley EH, Cheal K, et al. (2006). Satisfaction with mental health services in older primary care patients. *Am J Geriatr Psychiatry*. Apr;14(4):371-9.

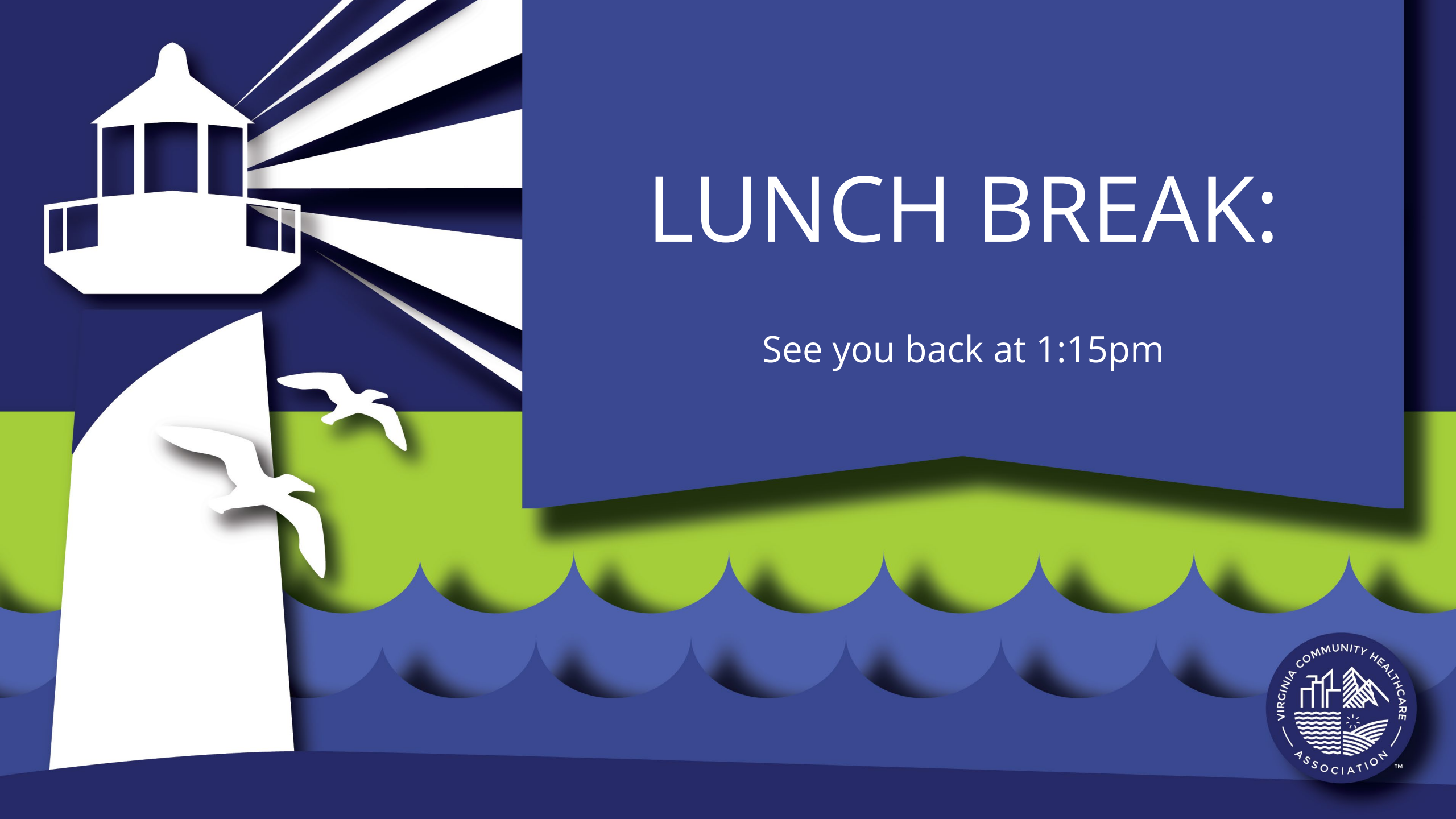
https://www.youtube.com/watch?v=xQxsp08nQd0&index=6&list=PL8896DBC33F556A00

Achieving the Quadruple Aim

- The ~~Triple~~ **Quadruple** Aim
  1. Outcomes
  2. Cost
  3. Patient Satisfaction
  4. Staff / Provider Satisfaction



https://digital.ahrq.gov/acts/quadruple-aim



LUNCH BREAK:

See you back at 1:15pm

Deeper Dive: Models of Care and Integration

Subsession 2

1:15 – 2:30pm

What is Integrated Care?

"The care a patient experiences as a result of a **team of Primary Care & 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."

Integrated Services, *n.* the provision and coordination by the treatment team of appropriately matched interventions for both physical health (PH) and behavioral health (BH) conditions, along with attention to social determinants of health (SDOH), in the setting in which the person is most naturally engaged.

Integratedness, *n.* 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 social determinants of health

The Rationale

Behavioral health and primary care providers have **shared responsibility**

$293B **added costs** due to mental health/ substance use co-morbidity with medical disorders

Decreased life span due to untreated or undertreated chronic medical conditions, **considerably** more for **certain ethnic groups**

SMI have **less access** to preventive care/care management for comorbid general illnesses

SMI have **higher prevalence** of preventable diseases and greater risk for **mortality** due to poor PCP access & prevention

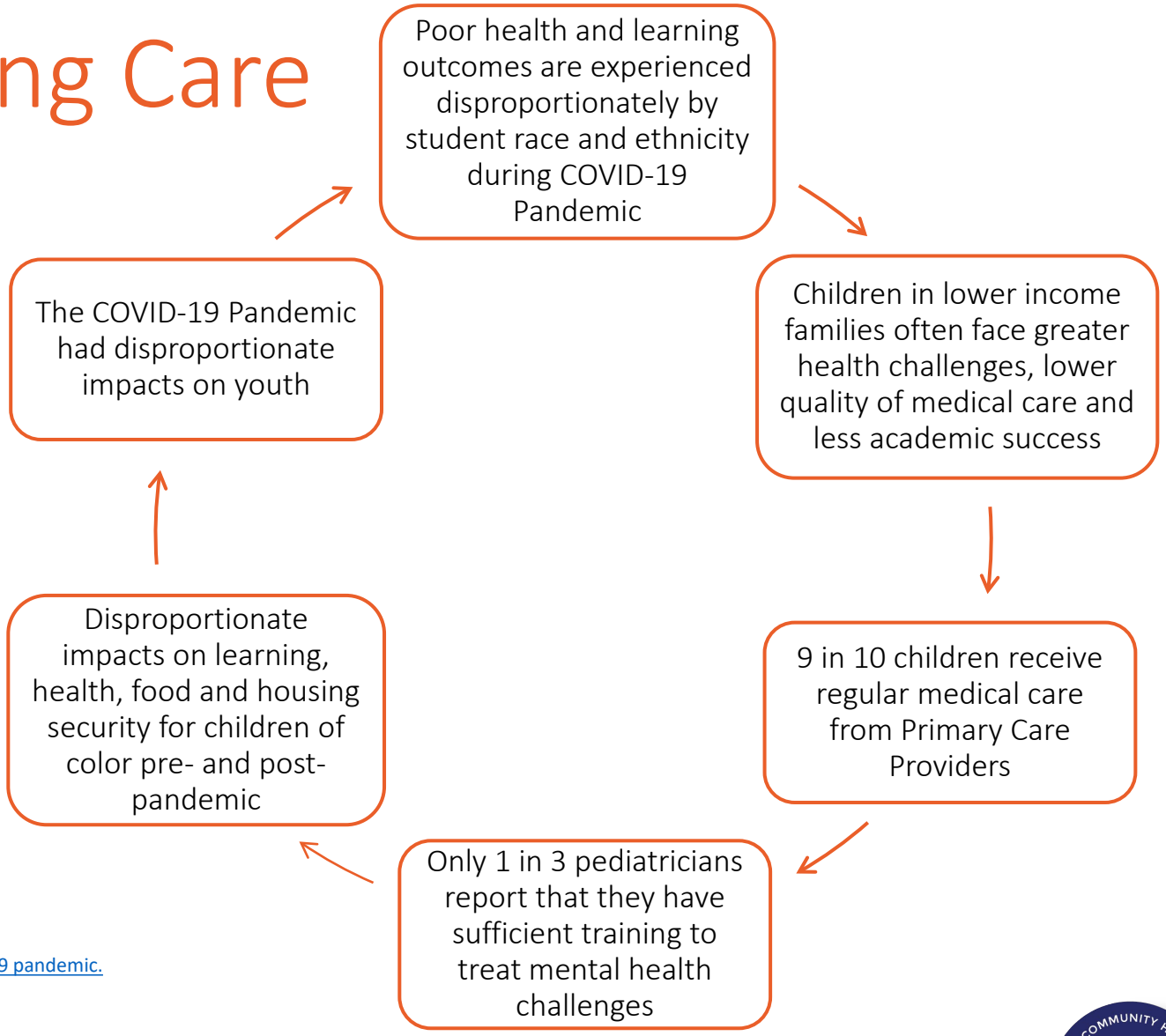
Overdose deaths have **increased** the **most** among racial/ethnic populations, **44%** for **Black people** and **39%** for **AI/AN people**.

BIPOC are **less likely** to have **access** and **use** community mental health services and **more** likely to receive poor quality of care

Integrated Care helps **eliminate barriers to access** and ensure that clients **receive whole person care**

Sources: Black men hit hardest by drug overdose deaths in recent years | Pew Research Center, Improving-Access-to-Effective-Care-for-People-Who-Have-Mental-Health-and-Sustance-Use-Disorders.pdf (nam.edu), https://doi.org/10.1186/s12991-021-00374-y, Integrating Mental Health and Substance Use Services with Primary Care Can Reduce Disparities for Communities of Color | Bipartisan Policy Center

Rationale for Integrating Care for Youth



Michigan State University, 2021. Racial/ethnic difference is education disruptions during the COVID-19 pandemic.

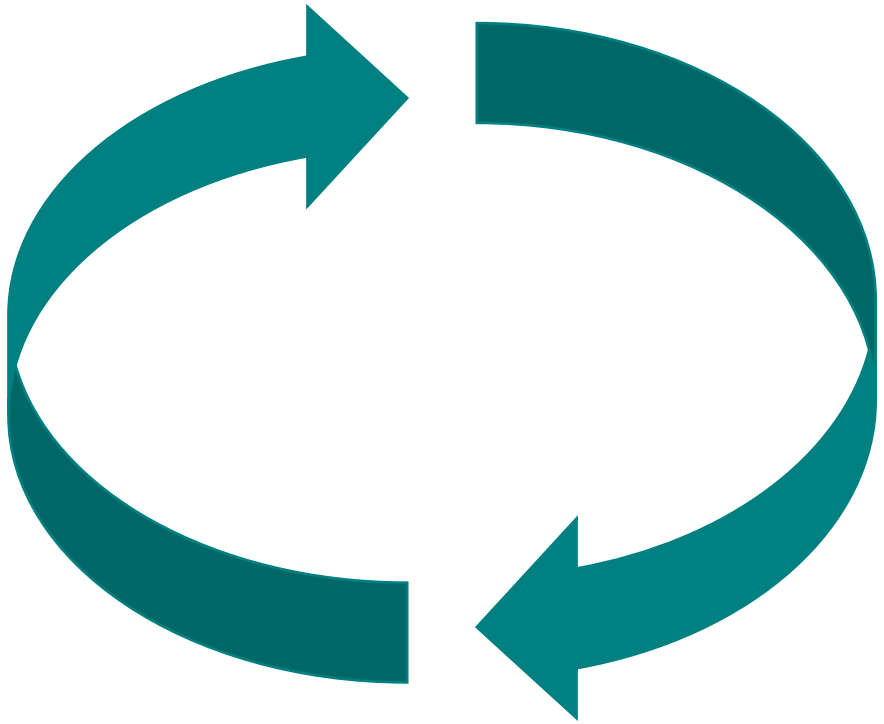
Why Integrated Care?

- **40 percent** in primary care have a mental health challenge.
- **27 percent** will suffer from a substance use disorder.
- **80 percent** with behavioral health concerns present in emergency departments or primary care clinics.
- **67 percent** with behavioral health disorders **do not receive care**.
- **68 percent** of adults with mental illness have **comorbid chronic health disorders**,
- **29 percent** of adults with chronic health disorders have mental illness.

Sources: American Hospital Association, *Trend Watch: Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes.* Washington DC: The American Hospital Association, January 2012); Maria A. Oquendo, November, 7, 2016, "CMS Shows Strong Support for Collaborative Care," American Pyschiatric Association Blog, November 7, 2016; Sarah Klein and Martha Hostetter, *In Focus: Integrating Behavioral Health and Primary Care* (New York: Commonwealth Fund, August 14, 2014), accessed May 17, 2021.

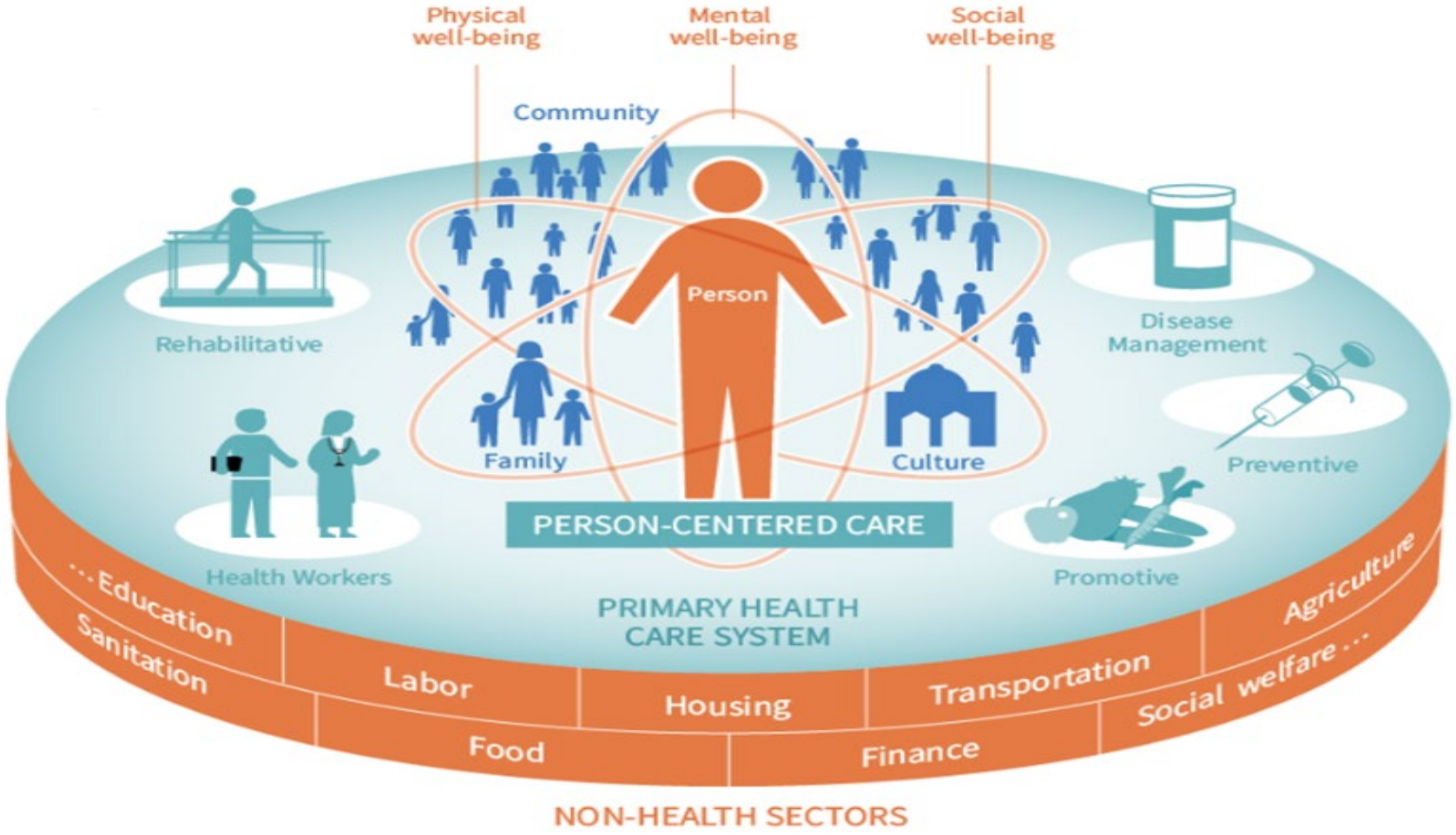
Bi-Directional Integration is Critical

Behavioral Health within Primary Care



Primary Care within Behavioral Health

A Better View of Integrated Care



Sources: https://improvingphc.org/file/comprehensiveness-4png, https://www.thenationalcouncil.org/wp-content/uploads/2022/04/04.22.2022_MDI-CHI-Paper_Reduced.pdf

Principles of Integrated Care

1. People-centered Interdisciplinary Teams
2. Comprehensive and Coordinated Continuum of Services
3. Defined Population and Outcomes
4. Systematically Measurement Informed
5. Evidence Based Interventions
6. Engagement with Broader Community
7. Accountable and Aligned Funding

Core Components of Integrated Models

1. Person-centered care
2. Population-based care
3. Data-driven care
4. Evidence-based care

Source: Beh Health Homes for People with MH & SA, 2012. http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf

Goals of Integrated Care

- Improving overall **health outcomes, for all clients**
- **Advancing health equity** for marginalized communities
- Expanding **identification and screening** for individuals with mental health and substance use challenges
- Avoiding hospital admissions and readmissions
- Reducing emergency room utilization
- Preparing practices for value-based payment models
- Reducing overall health care costs

Considerations for Integration

- **Capacity:** Size and volume, resources available and variety in patient treatment programs
- **Infrastructure:** Electronic health records, tracking and registry, care coordination, regulatory and payment incentives
- **Implementation support:** Technical assistance, quality improvement and measurement, multidisciplinary team

Team-based Care & Workforce Preparation

People with distinct disciplinary training working together for a common purpose, as they make different, complementary contributions to patient-focused care.

Source: Leathard , A., ed. (1994). *Going Interprofessional: Working Together for Health & Welfare.* Routledge, London.

"The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system."

Source: Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.5.

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, payers, and providers 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.

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
- Not focusing on sustained or expanded funding beyond initial grant funding

Barriers to advancing Integrated Care

Workforce

Systemic Healthcare Barriers

Social Determinants

Stigma and Mistrust

Funding Sources

Infrastructure

Model Limitations

Its about changing the system for our communities

"You never change things by fighting the existing reality.

To change something, build a new model that makes the existing model obsolete."

— R. Buckminster Fuller

Why do we need a new framework now?

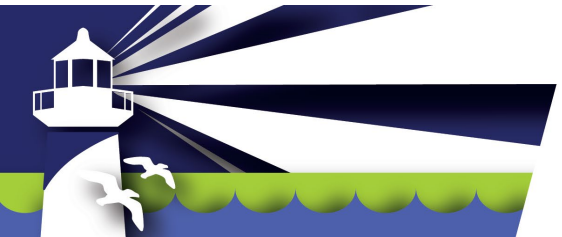
People living with co-occurring Physical Health, Behavioral Health and SDOH needs:

- 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.

Source: Comprehensive Healthcare Integration Framework.

Models and Frameworks for Integrated Care



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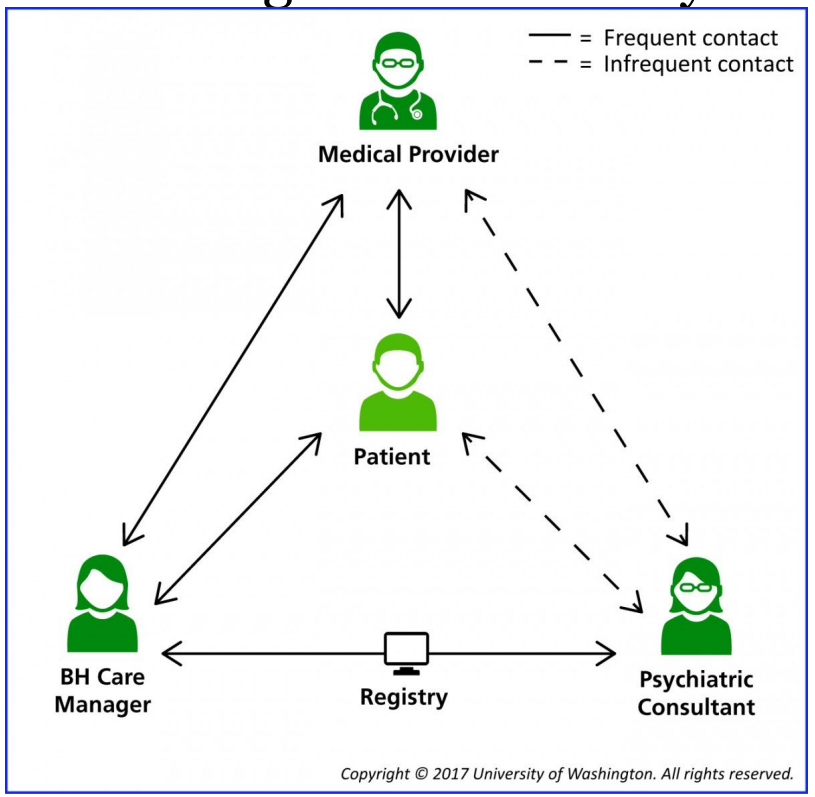
Models and Frameworks:
Collaborative Care Model (CoCM, AIMS Center/ Project IMPACT)

Goal

- Enhance treatment and management of patients with BH diagnoses efficiently and with frequent touch points

Overview

- Focused on specific populations
- Typically, anxiety and depression
- Model elements
- Registry-based to track, coordinate care
- "Care manager" delivers brief interventions
- CBT, BA, PST
- Psychiatric oversight of care manager and PCP
- "Treat to target" w/ standardized outcome tools
- Acknowledgement* by CMS, APA

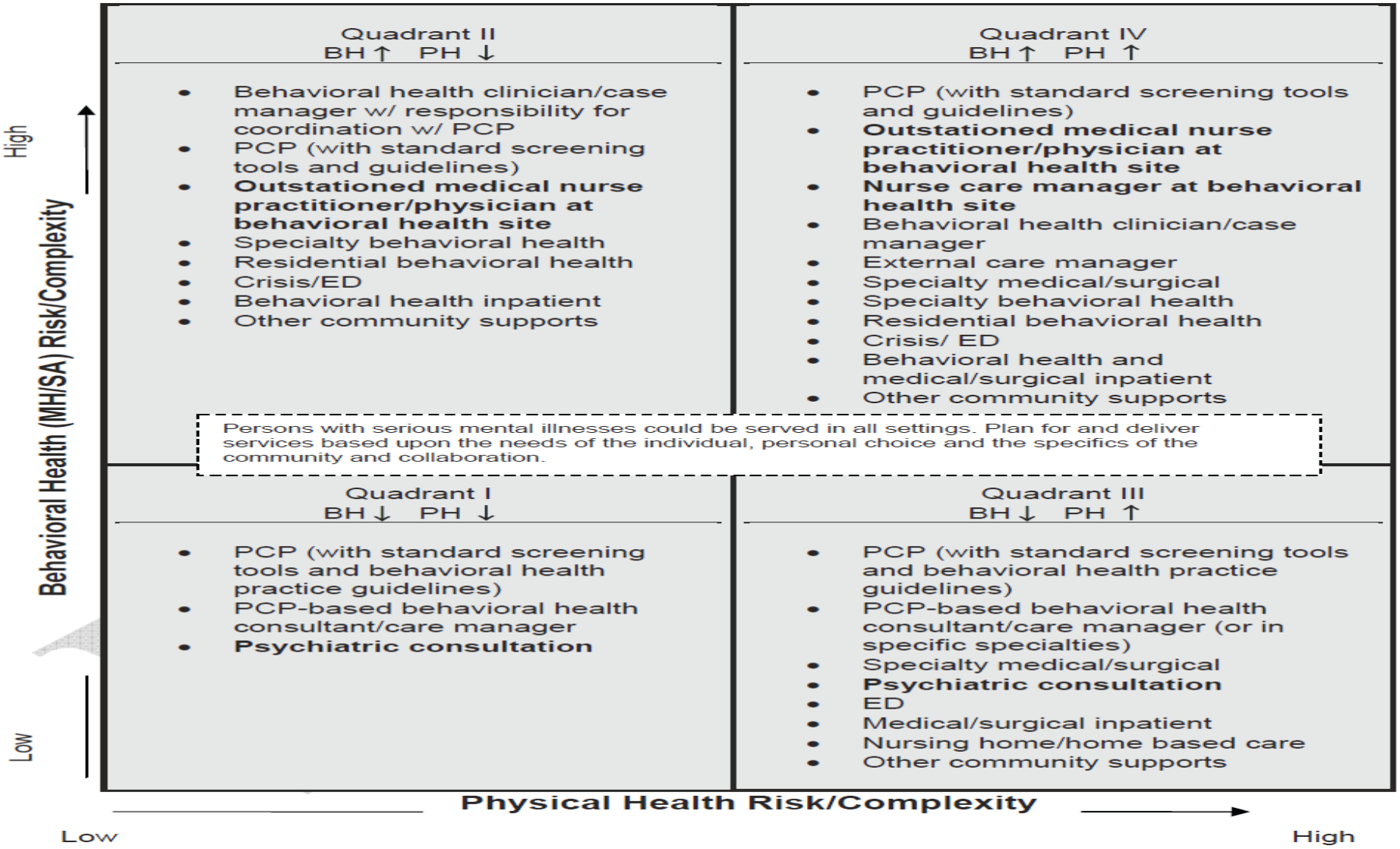


Source: Uni of Washington AIMS Center Website

Models and Frameworks:
Primary Care Behavioral Health Model

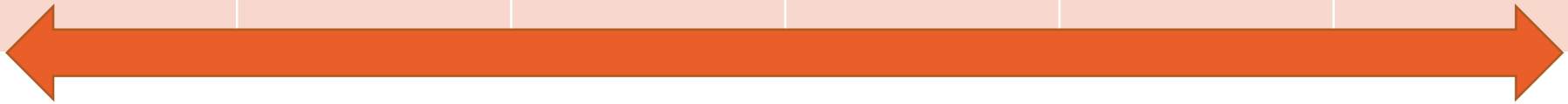
- Overview
  - Team-based primary care approach to managing behavioral health condition that adds a “BHC” to the team
  - BHC is a generalist, typically incorporates elements of health promotion and behavioral medicine
  - Brief, solution-focused visits (typically 4)
  - Population-wide focus (PCP’s population = BHC’s population)
  - Frequent consultation to PCP and nursing
  - High emphasis on open access
- Goal
  - Enhance the *primary care team’s ability* to manage and treat conditions, with resulting improvements in primary care for the entire population

Models and Frameworks:
The Four Quadrant Clinical Integration Model



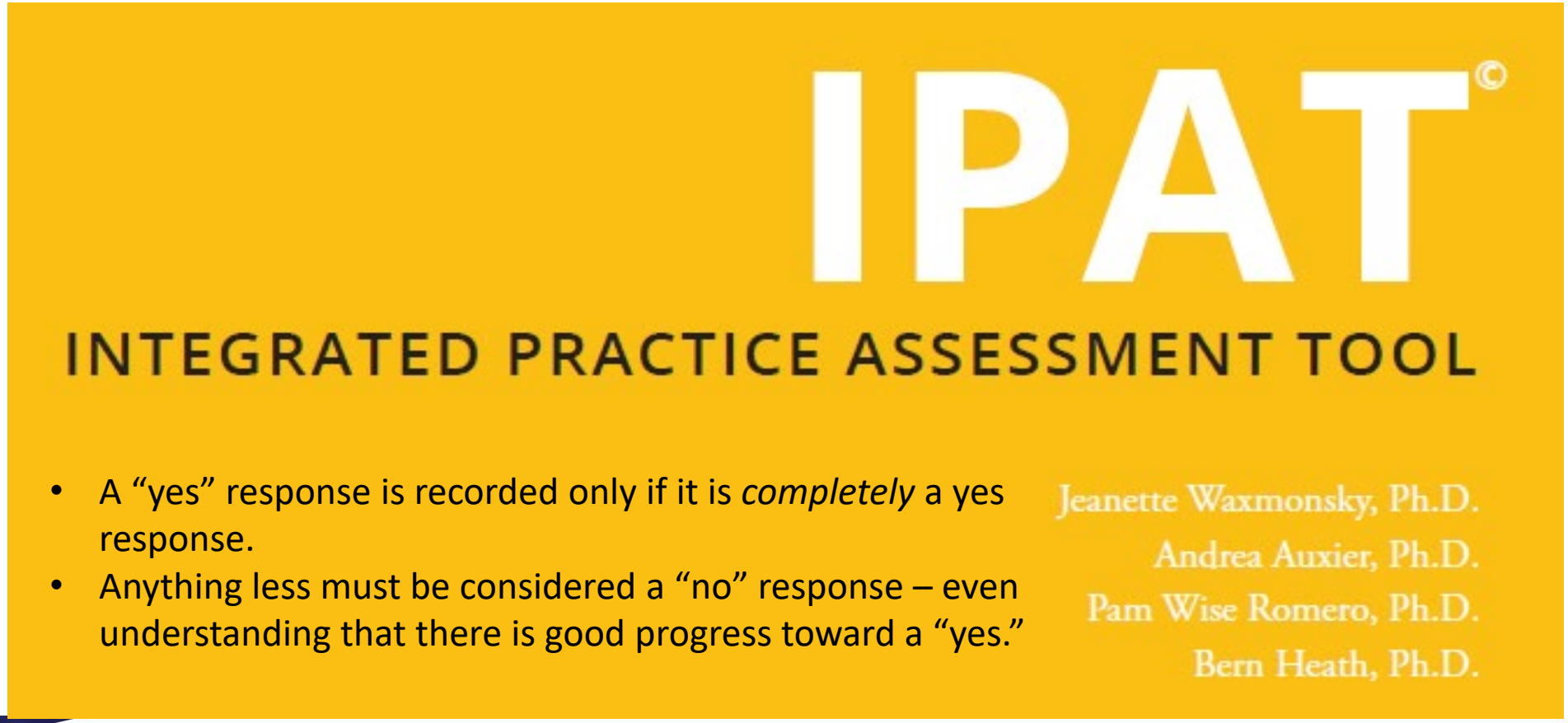
Models and Frameworks:
SAMHSA Six Levels of Collaboration and Integration

Coordinated Key Element: Communication		Co-located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
Level 1: Minimal collaboration, siloed care	Level 2: Basic collaboration, separate locations	Level 3: Basic collaboration on-site	Level 4: Close collaboration on-site with some system integration	Level 5: Close collaboration approaching and integrated practice	Level 6: Full collaboration in a transformed practice



Sources: SAMHSA-HRSA Center for Integrated Health Solutions, *A Standard Framework for Levels of Integrated Healthcare and Update Throughout the Document* (Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions, March 2013), 10.

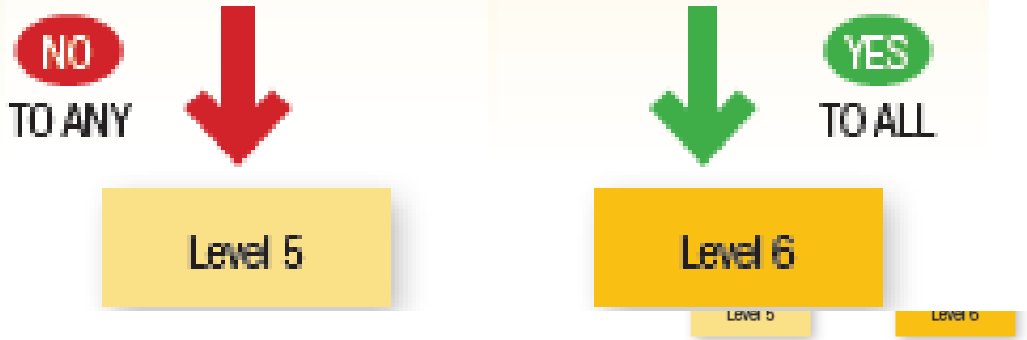
Models and Frameworks:
Integrated Practice Assessment Tool (IPAT)



- A “yes” response is recorded only if it is *completely* a yes response.
- Anything less must be considered a “no” response – even understanding that there is good progress toward a “yes.”

https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Integrative%20Practice%20Assessment%20Tool%20(IPAT).pdf

a. Are resources balanced, truly shared, and allocated across the whole practice?
b. Is all patient information equally accessible and used by all providers to inform care?
c. Have all providers changed their practice to a new model of care?
d. Has leadership adopted and committed to integration as the model of care for the whole system?
e. Is there only 1 treatment plan for all patients and does the care team have access to the treatment plan?
f. Are all patients treated by a team?
g. Is population-based screening standard practice, and is screening used to develop interventions for both populations and individuals?
h. Does the practice systematically track and analyze outcomes for accountability and quality improvement?



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oads/TI/CoreComponents/Integrative%20P
ice%20Assessment%20Tool%20(IPAT).pdf

Models and Frameworks:
Patient-Centered Medical Home (PCMH)

PROGRAM CONCEPT AREAS

- **Team-Based Care and Practice Organization:** Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families and caregivers.
- **Knowing and Managing Your Patients:** Sets standards for data collection, medication reconciliation, evidence-based clinical decision support and other activities.
- **Patient-Centered Access and Continuity:** Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.
- **Care Management and Support:** Helps clinicians set up care management protocols to identify patients who need more closely-managed care.
- **Care Coordination and Care Transitions:** Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.
- **Performance Measurement and Quality Improvement:** Improvement helps practices develop ways to measure performance, set goals and develop activities that will improve performance.

Models and Frameworks:
General Health Integration (GHI)

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

Models and Frameworks:
Comprehensive Health Integration (CHI)

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

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

Source: Comprehensive Healthcare Integration Framework.

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

Components of the CHI Framework

Three Constructs - elements of "**integratedness**"

Eight Domains – Care processes

Integration Metrics

Integration Payment Methods

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

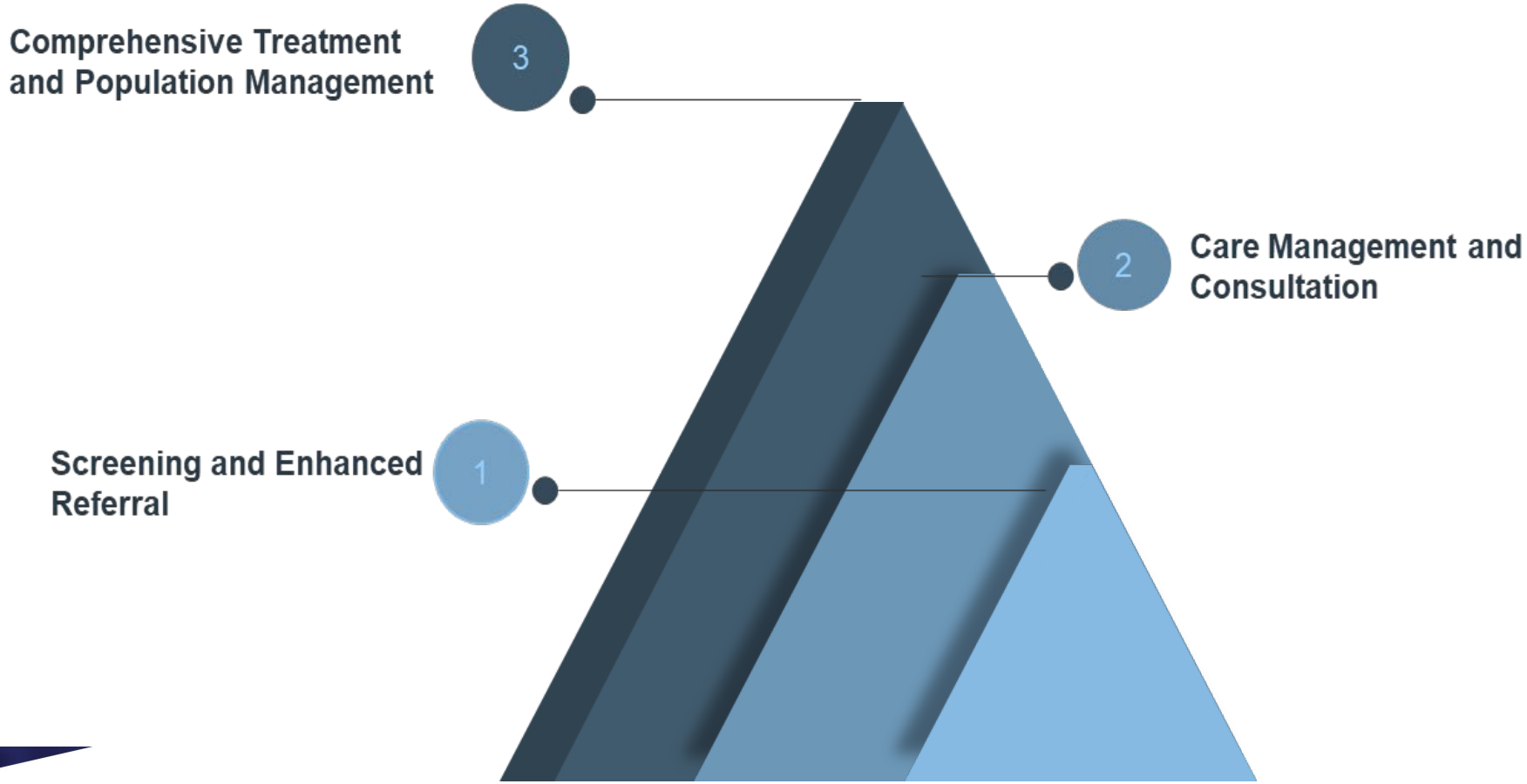
- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and are management

Integration Construct 3:
Comprehensive Treatment and Population Management

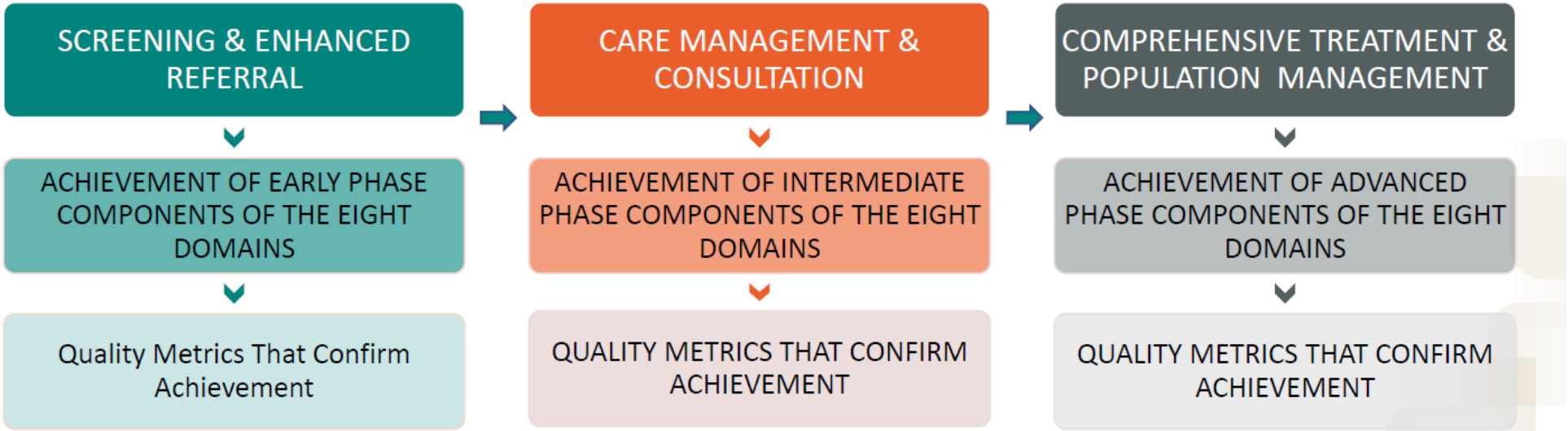
- Typically requires comprehensive PH and BH staffing in a single organization (hospital, independent clinical practice, FQHC, etc.)
- Measures improved health outcomes along the Domains

The Three Integration Constructs

The Constructs build on each other as organizations make progress



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



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.

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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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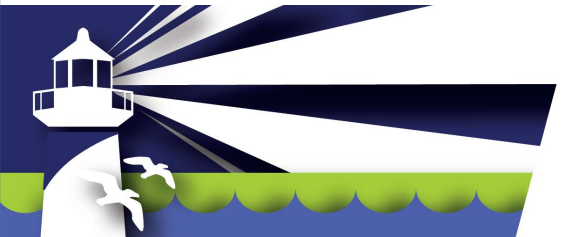
3. Ongoing Care Coordination and Care Management.	**3.1** Longitudinal clinical monitoring and engagement for addressing prevention and intervention for co-occurring PH and/or BH conditions.	No/minimal mechanisms for routine coordination and f/u of patients referred to PH or BH care.	Provider team has 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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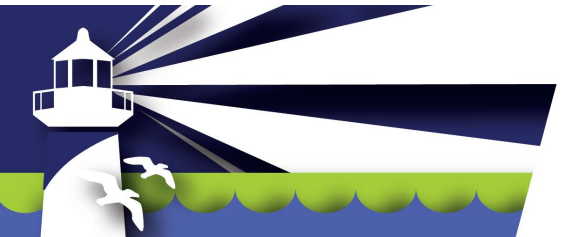
6. Systematic quality improvement (QI).	**6.1** Use of quality metrics for PH/BH integration improvement and/or external reporting.	No/minimal use of PH and/or BH quality metrics	Limited tracking of co-occurring PH and/or BH quality metrics for people served and/or for state or health plan reporting. 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.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
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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

Metrics for Integration Construct 1: Screening and Enhanced Referral

Behavioral Health 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.

Physical Health 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.

Financing Goals

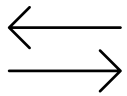
Initial implementation of an Integrated Construct

Strengthening an Existing Construct

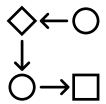
Incentivizing Progress from One Construct to the Next

- **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.

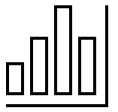
Types of Payment Methodologies for Integration



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



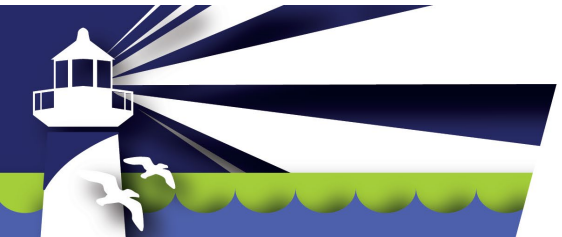
Care Enhancement Payments (usually per-member per-month (PMPM) or perspective payment system (PPS)



Value-based payments (VBPs): usually a supplemental payment

Matching Payment Methodology to Sustainability of Each Integration Construct

Integration Construct 1: Screening and Enhanced Referral	1. A time-limited start up grant to cover initial implementation costs
	2. CPT code services that specifically support integration with rates set to adequately cover costs and incentivize uptake.
	3. Value-based incentive payment for timely implementation of the necessary screening and referral structures or performance measures related to screening and referral



What's billable? It's more than one question

- What codes are billable?
  - What **provider type/licensure level** is reimbursable?
- What codes are **diagnostically** reimbursable?

Table 3. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Codes

	Has the state approved SBIRT codes for use?	Has the state turned on the SBIRT codes in their Medicaid system so you can bill and receive payment?
State:		
AK	No	No
AR	No	No
CO	Yes	No
CT	No	No
DC	No	No
FL	No	No
GA	No	No
HI	No	No
ID	No	No
IL	No	No
IN	Yes	Yes

https://www.nachc.org/wp-content/uploads/2015/11/MentalHealthSA_PPSReport-Final-Nov-2010.pdf

NATIONAL COUNCIL for Mental Wellbeing

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.

Annual Reach Goals: 50,000 individuals

Virginia Community Healthcare Association Annual Meeting and Conference
September 27–29

CoE-IHS Offerings:

Interested in an individual consultation with the CoE experts on integrated care?
Contact us through this form here!

ECHO and Learning Collaborative Opportunities

Live and On-demand webinars and trainings

Resources & Tools

Looking for free trainings and credits?
Check out integrated health trainings from Relias here

Subscribe for Center of Excellence Updates
Subscribe here

BREAK:

See you back in...

Addressing the Workforce Crisis and Skill building

Subsession 3

2:30 – 4:00pm

The Behavioral Health Workforce Crisis

- 160 million Americans live in areas with mental health professional shortages, with over 8,000 more professionals needed to ensure an adequate supply.

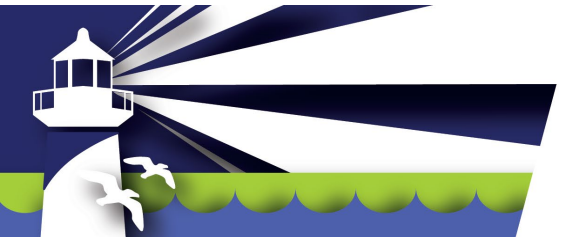
https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage

What's Happening in Rural Communities

65% of non-metropolitan counties do not have a psychiatrist & 47% do not have a psychologist (American Journal of Preventive Medicine)

Rural Hospitals are closing at an alarming rate (Chartis Center for Rural Health)

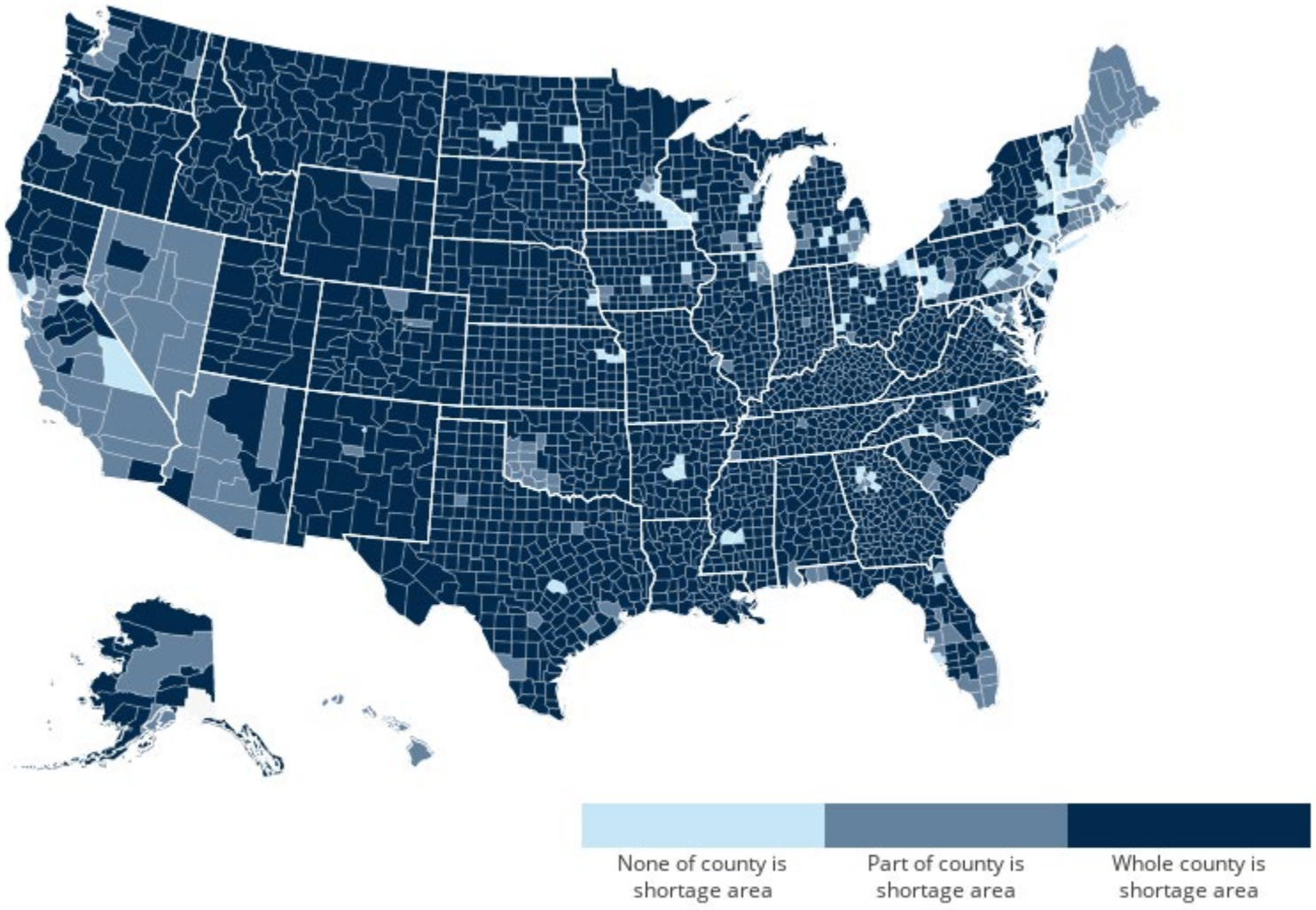
Suicide, substance use, and addiction disproportionately affect rural America (Rural Policy Research Institute)



SU Workforce Crisis

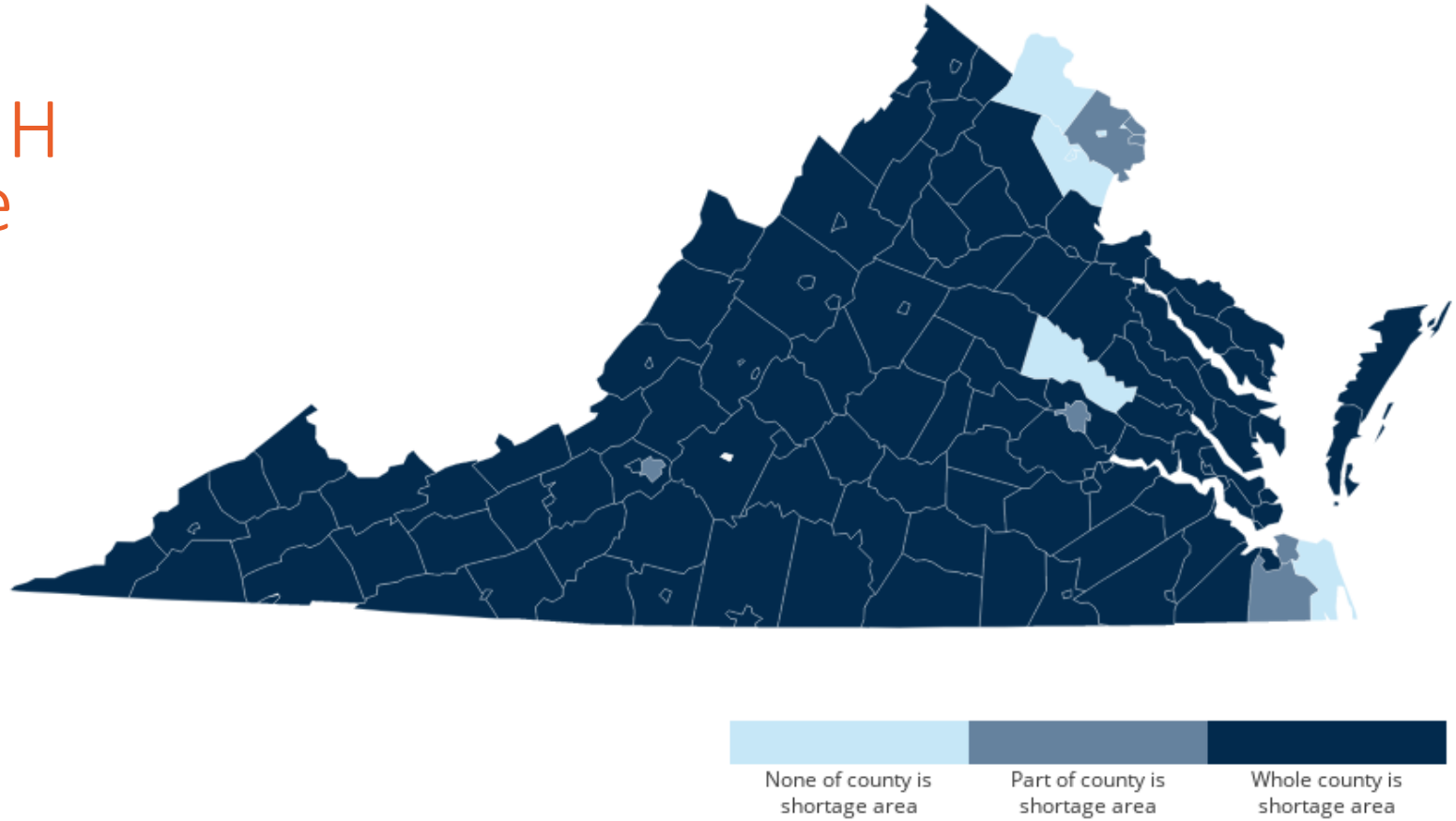
- By 2030
  - The supply of addiction counselors projected to be low
  - The demand for addiction counselors is projected to be high
- Each year, 25% of SUD clinicians leave the job
- Workforce shortages → decreased access to care f

MH Workforce Shortages



RHIhub Rural Health Information Hub

Virginia's MH Workforce Shortage



RHIhub Rural Health Information Hub

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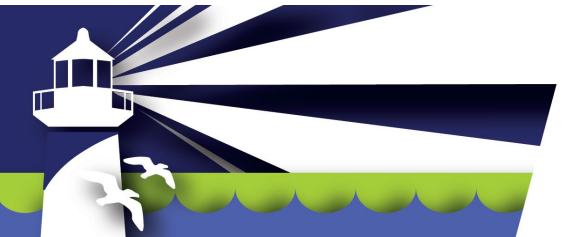
Future supply and demand for behavioral health practitioners will be affected by a host of factors related to **population growth, aging of the nation’s population, overall economic conditions, expansion of insurance coverage, changes in health care reimbursement, retirement, attrition, availability of training, and geographic location** of the health workforce.” HRSA



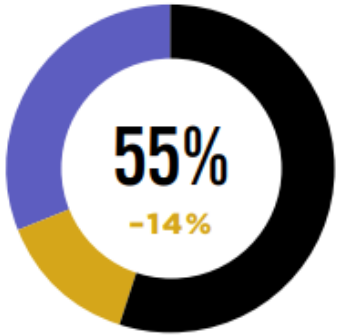
Challenges

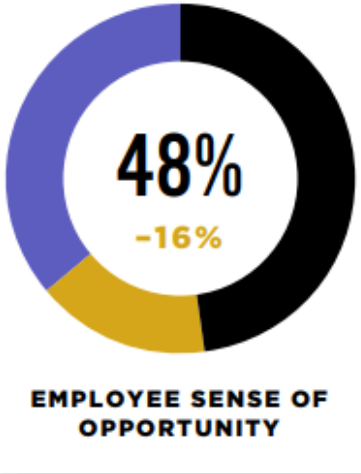
Demand for services continues to increase

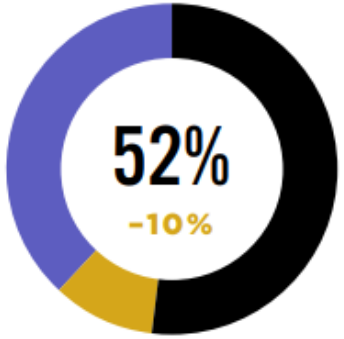
Waitlists are growing

Challenges with recruitment and retention

Additional funding and attention to administrative burdens are needed







"Helping employees to feel connected to purpose, accomplishment and one another – no matter when and where they work – is more important than ever"

Top Concerns

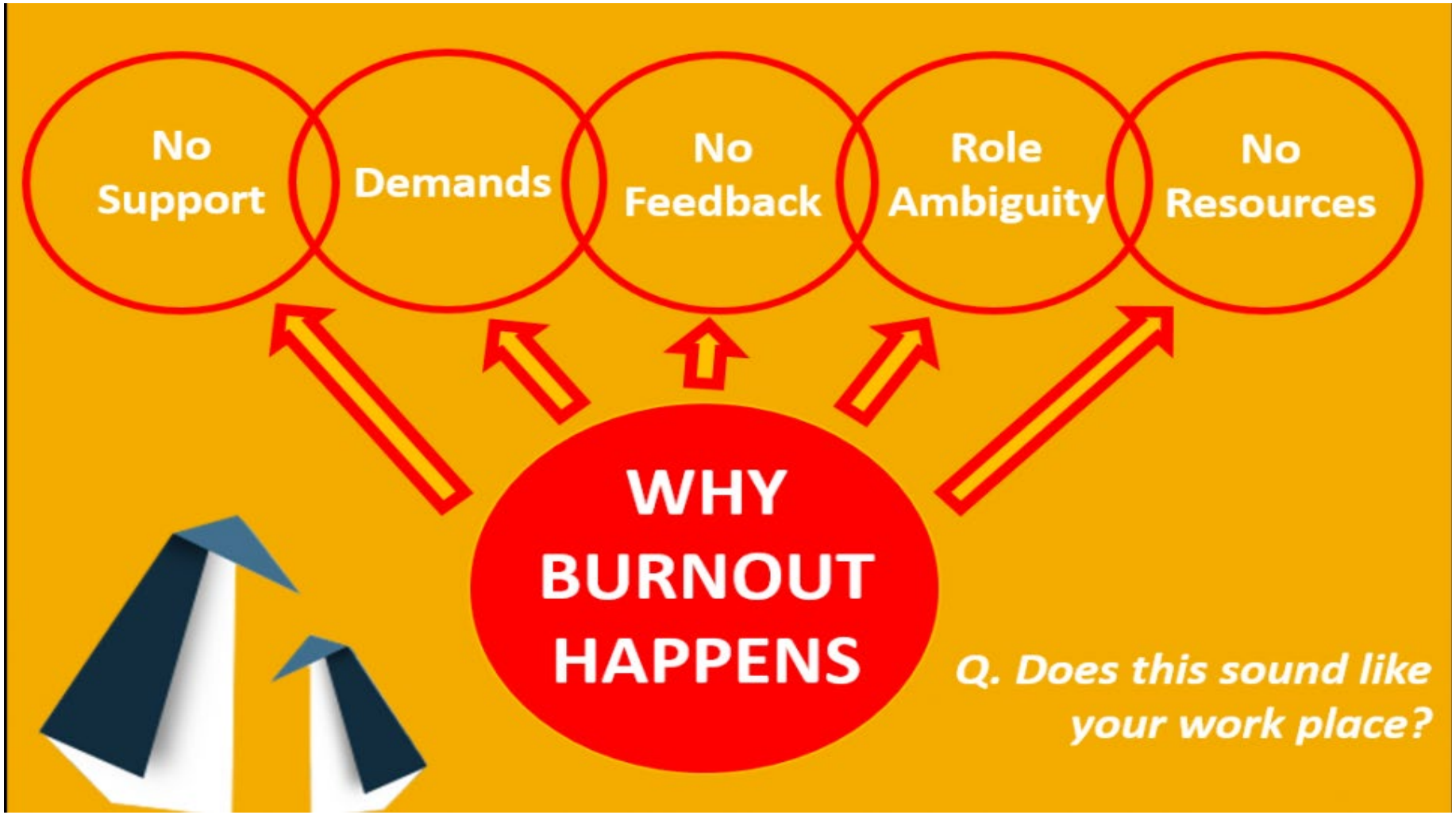
- Staffing Shortages & Turnover rates
- Qualified & Engaged Staff
- COVID Burnout
- Client Need
- Adequate Training
- Staff Burnout & Compassion Fatigue

Burnout – The Exhaustion Cycle

- A syndrome of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment
- Develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically

THE EXHAUSTION CYCLE

Source: National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011).

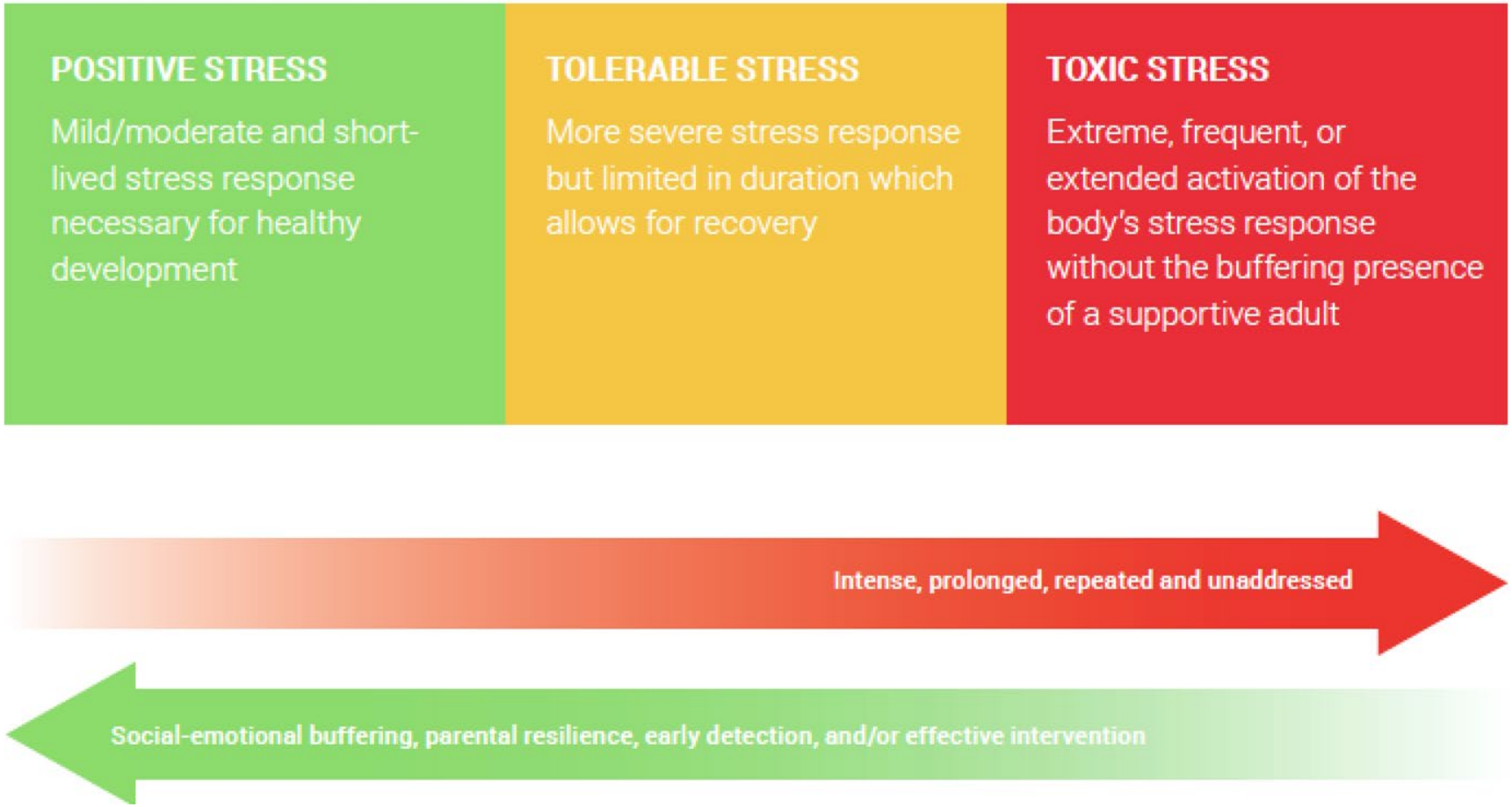


Source: http://blog.imonomy.com/prevent-employee-burnout-company-grows/

Compassion Fatigue

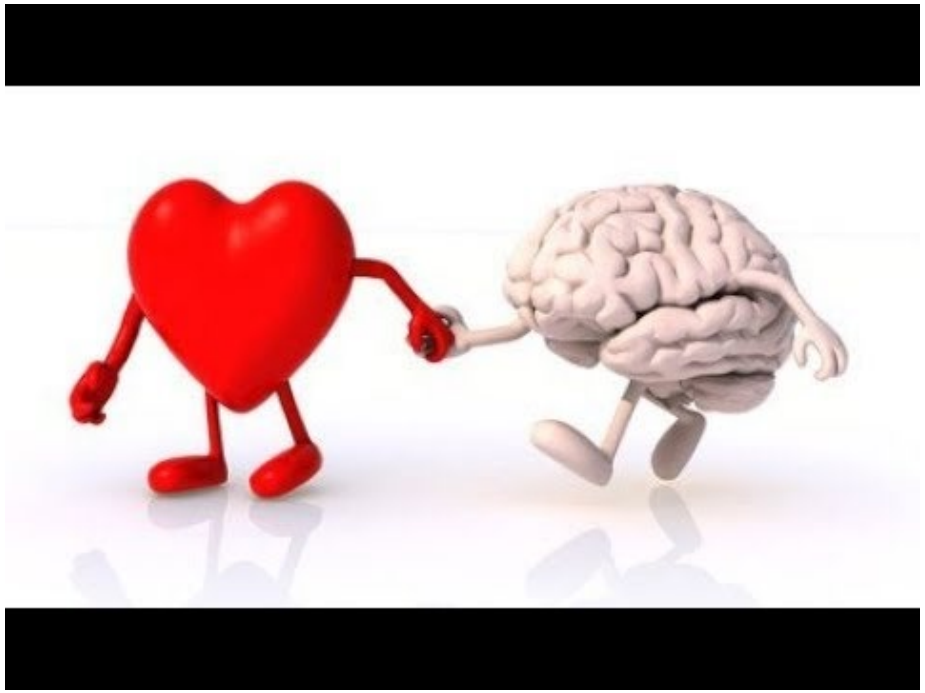
"What is to give light must endure burning" -- Viktor Frankl

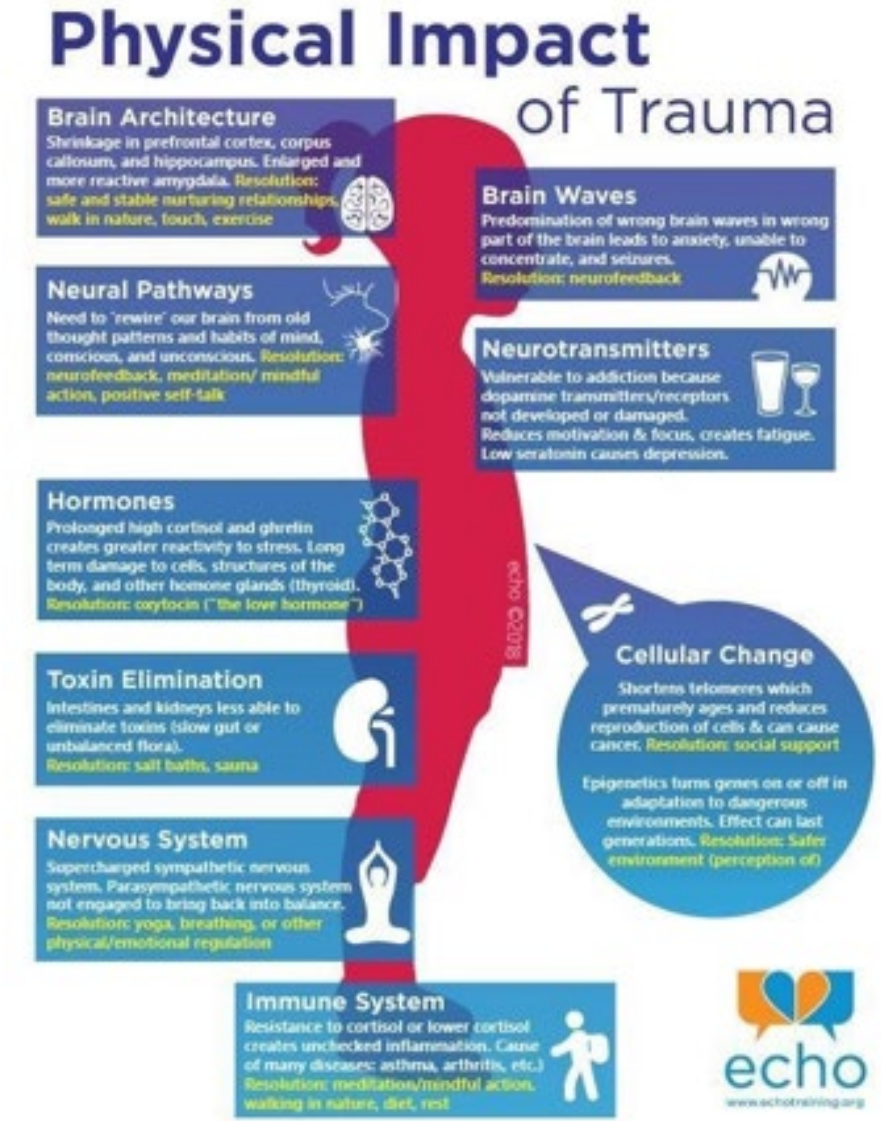
Continuum of Stress



“…a brain aware perspective helps me when I’m trying to understand people.”

Dr. Bruce D. Perry





Source: [Untitled Graphic Physical Impact of Trauma]. Retrieved from Echo Development Group.

Survival Mode Response

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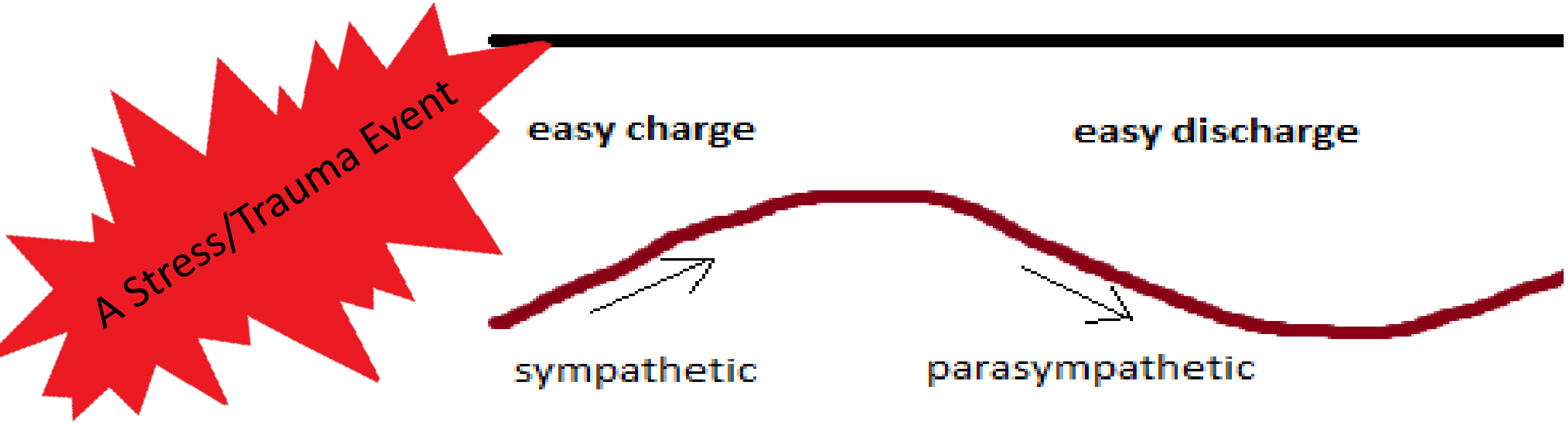
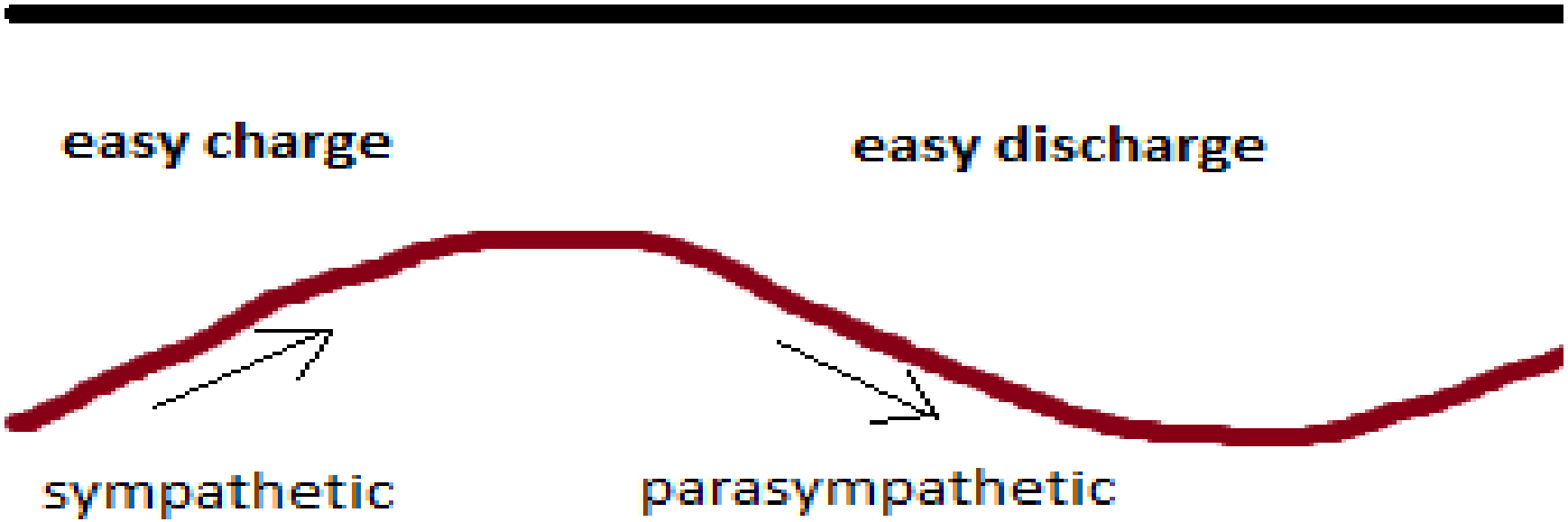
Discharge of Stress / Trauma



Parasympathetic (rest and digest)

Sympathetic
(fight, flight or freeze)

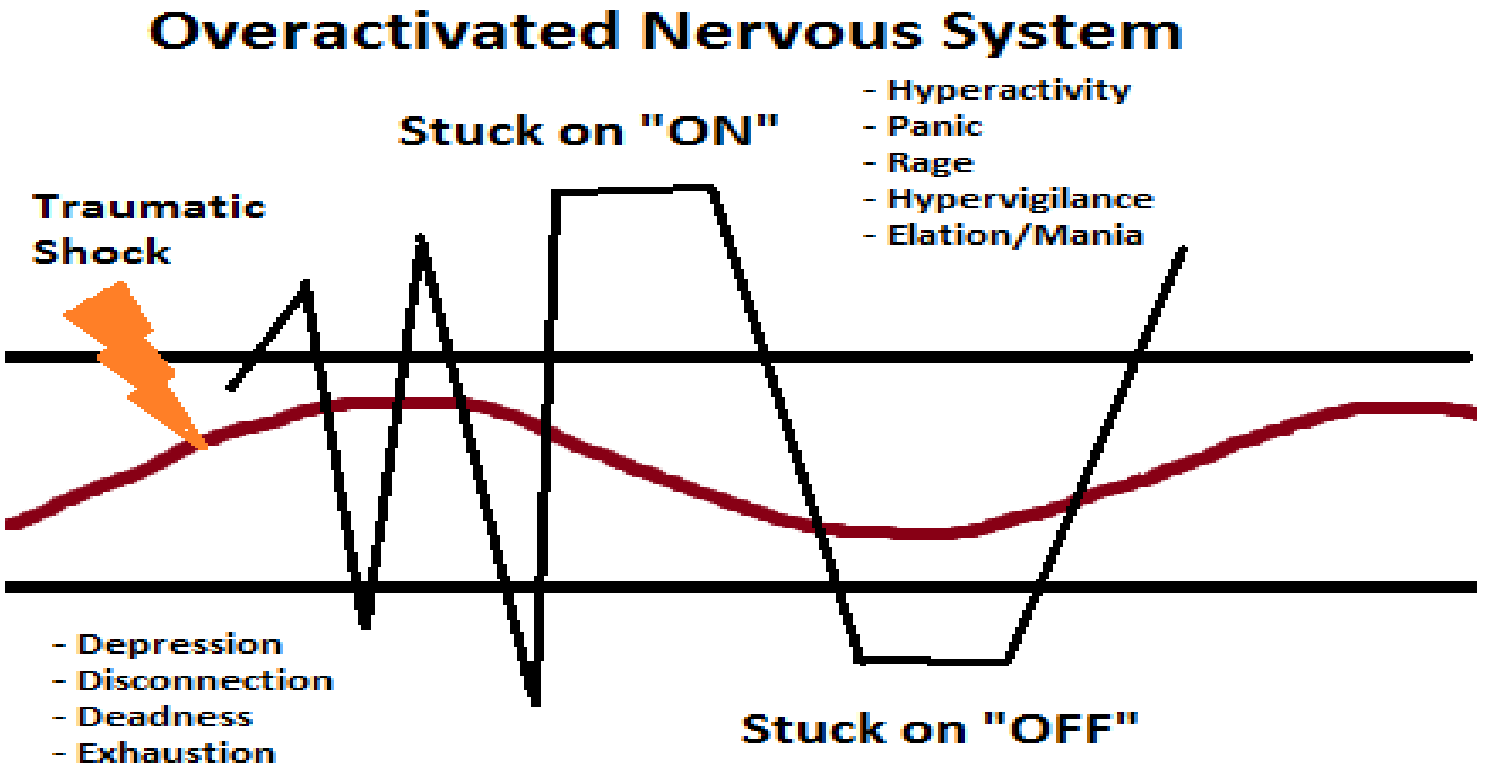
Discharge of Trauma




FIGHT
FLIGHT oohlala!
FREEZE

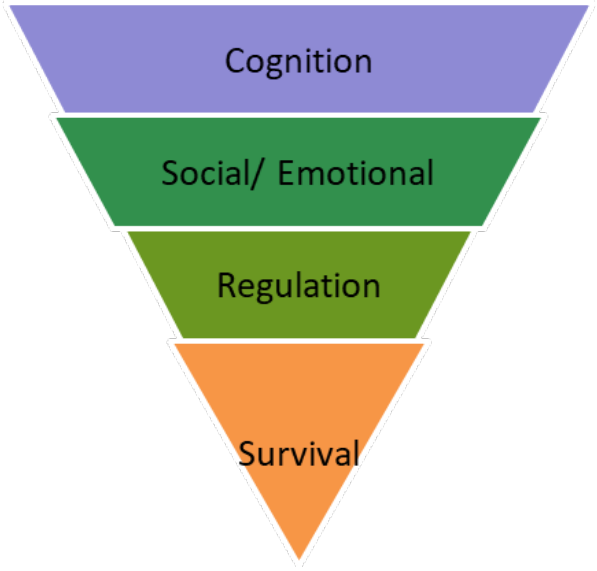

FIGHT
FLIGHT Oohlala!
FREEZE
FIGHT
FLIGHT Oohlala!
FREEZE

When Stress and Trauma are Not Processed

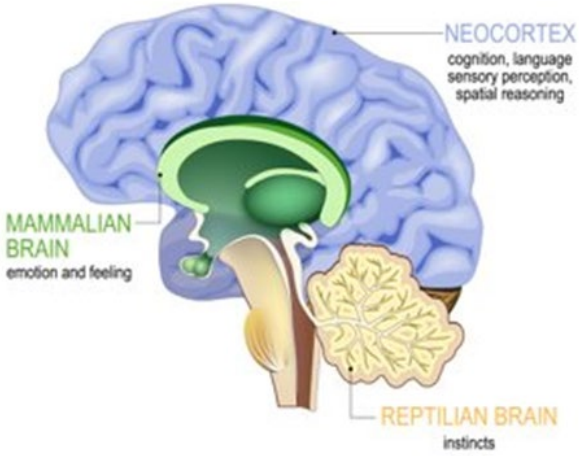


Impact of Stress on Brain Energy

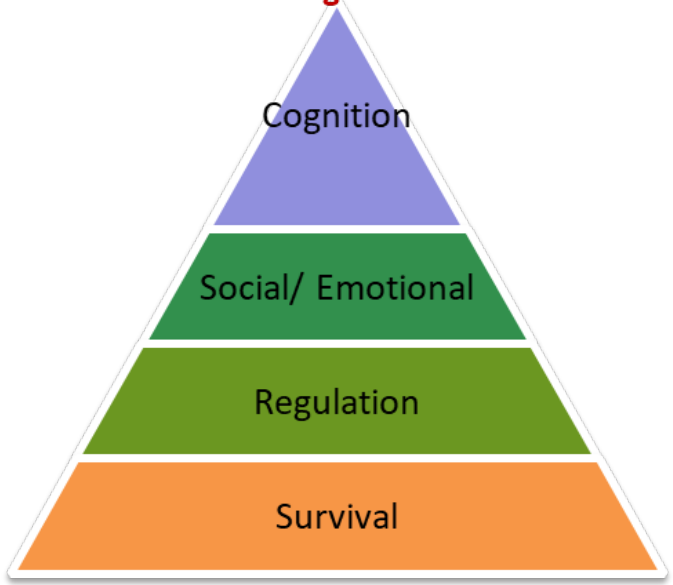
Typical Performance



Brain evolution



During Stress



Brain-Based Science

Neocortex and Prefrontal Cortex (PFC): Executive Functioning

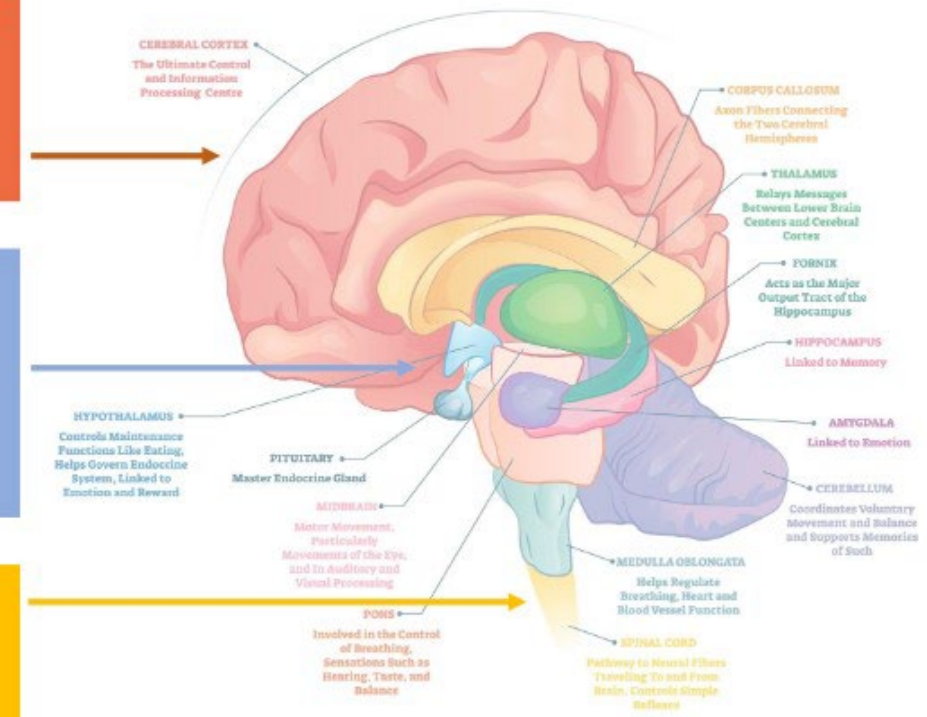
What can I learn?

Limbic System: Emotions and Memory

Am I loved?

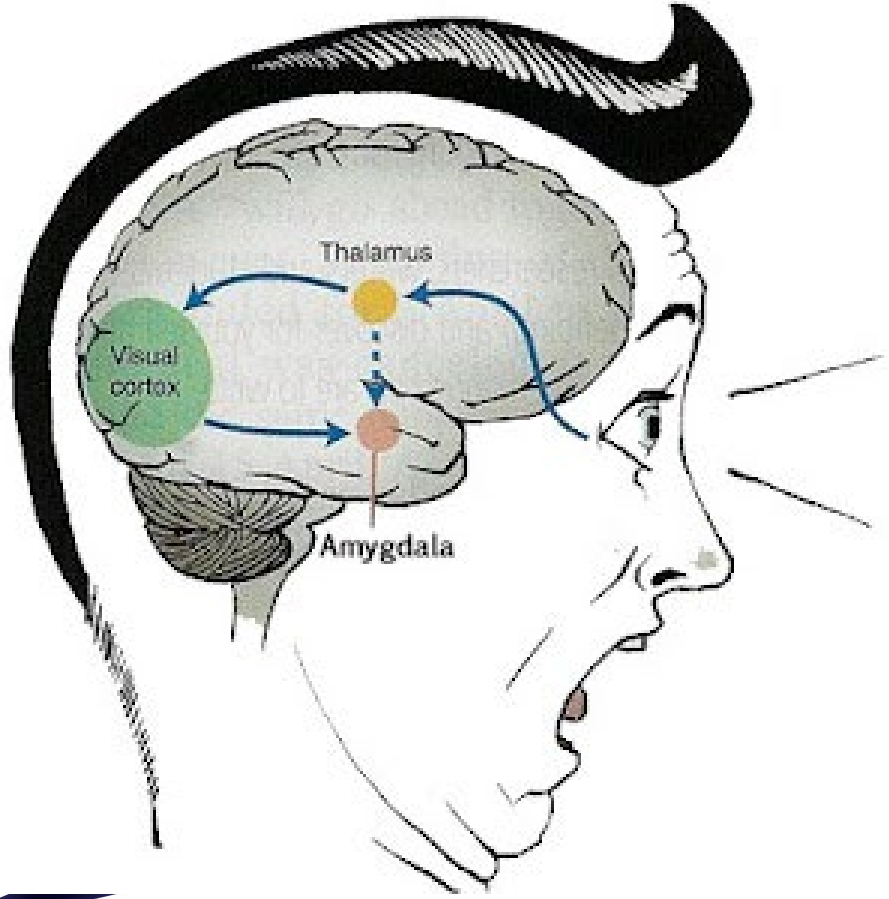
Brain Stem: Appraisal & Survival Functions

Am I safe?



https://drarielleschwartz.com/neurobiology-traumatic-memory-dr-arielle-schwartz

Stress on the Brain: Survival Mode Response

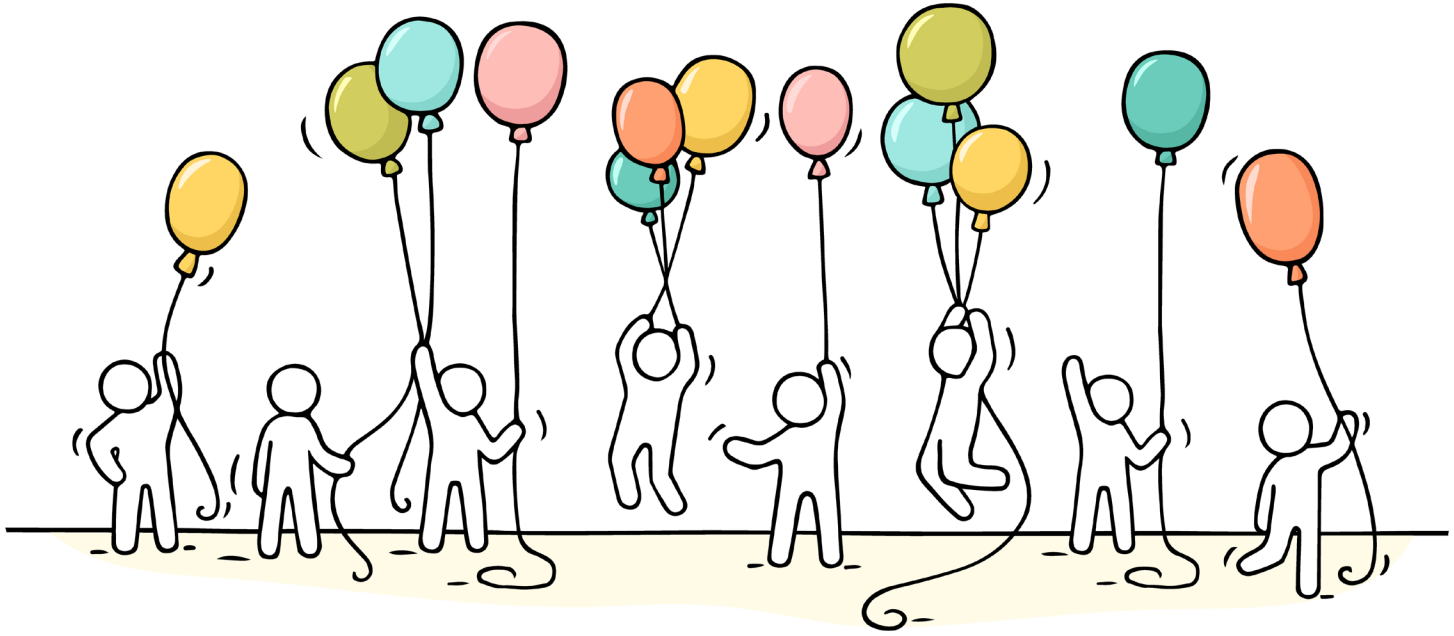


Inability to

- Respond
- Learn
- Process

Counteract Burnout and Compassion Fatigue

Creating and Sustaining a Culture of Compassionate Resilience



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What is a Trauma-Informed, Resilience-Oriented, Equity-Focused Approach?

Realizes

Recognizes

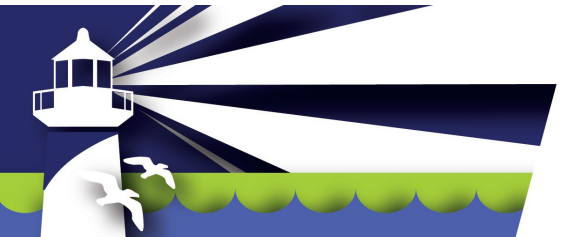
Responds

Resists

From SAMHSA's Concept Paper

Principles of a Trauma-Informed, Resilience-Oriented, and Equity-focused Approach

Physical Safety	The sense of being protected from violence, illness etc.
Psychological Safety	Addressing the anxieties and fears of being able to be authentic, risk taking
Cultural Safety	Addressing cultural, historical and gender identity and expression
Moral Safety	Addressing the **hypocrisy** that is present, both **explicitly and implicitly**
Social Safety	Ability to be appreciated & true self amongst others, in particular diversity of thinking
Intellectual Safety	Open sharing of ideas and ability to make mistakes and learn from them



Principles of a Trauma-Informed, Resilience-Oriented, and Equity-focused Approach

What Does a Trauma-Informed, Resilience-Oriented Equity-Focused Organization Include?

- **Safe, calm, and secure environment with supportive care for staff and clients**
- **System-wide understanding of trauma prevalence, impact, resilience and trauma-informed care**
- **Cultural humility, diversity, equity, inclusion and engagement**
- **Client and staff voice, choice and advocacy**
- **Resilience-oriented, person-driven, trauma-specific services**
- **Healing, hopeful, honest and trusting relationships**

Elements that Encourage Resilience

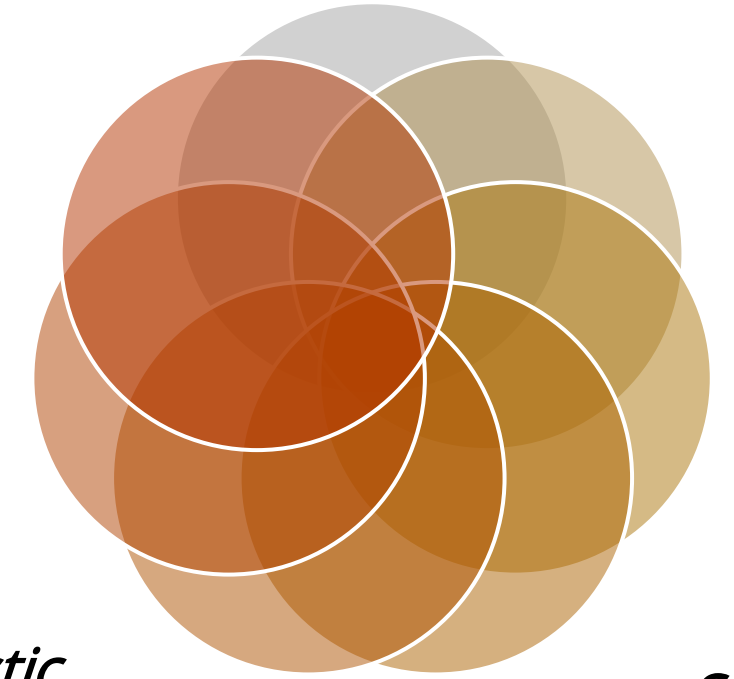
- Feeling valued.
- Believing that your voice can be heard and matters.
- Feeling supported.
- Believing you have the resources to function, do your job, etc.

Teach Resilience Skills:
Ability to adapt well to stress, adversity, trauma, or tragedy

Emotional regulation

Reaching out

Impulse control



Empathy

Accurate identification

Realistic optimism

Self-efficacy

Resilience Building Strategies

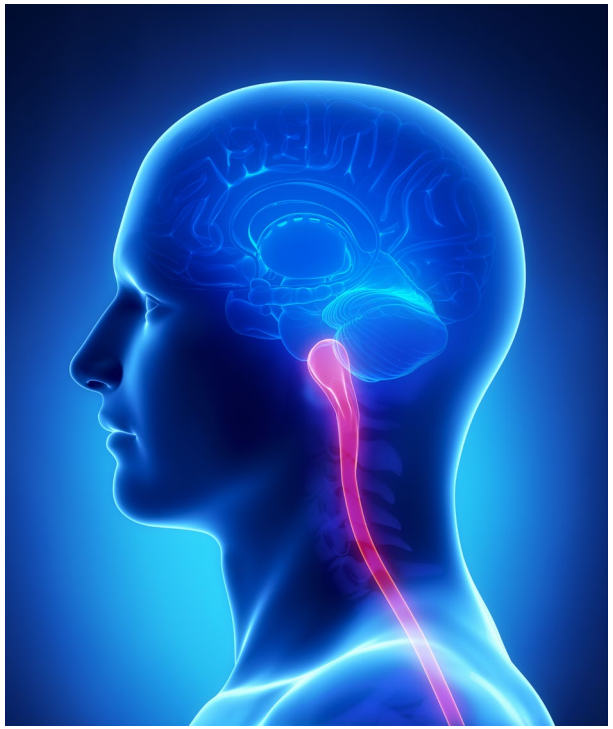
- Make connections
- Avoid seeing crises as insurmountable problems
- Accept that change is a part of living
- Move toward your goals
- Take decisive actions
- Look for opportunities for self-discovery
- Nurture a positive view of yourself
- Keep things in perspective
- Maintain a hopeful outlook
- **Take care of yourself**

The ABCs of Self Care and Compassion Resilience

- **Awareness**
  - Of your own experiences
  - Of your thoughts and feelings
  - Of resources and support
- **Balance**
  - Professional boundaries
  - Work, play, rest
  - Types of work
- **Connection**
  - To yourself
  - To others
  - To a bigger perspective – the bigger picture

Impacting the Lower Brain

- Rhythmic
- Respectful
- Rewarding



- Repetitive
- Relational
- Relevant

Success in Motion!

Improved Nutrition

Principle:

Eating better helps us feel better

The Benefits of Sleep

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SELF-SOOTHING

Self-soothing is a quick and effective way to reduce the intensity of negative emotions.

Sight

Low lighting
Soothing colors
Sleeping masks
Coloring books
Pinterest Collages

Touch

Soft things
Cuddle things
Massage
Hot/cold shower
Heated/weighted blanket

Sound

Calming noise
ASMR videos
Nature sounds
Guided meditations
Binaural beats

Smell

Aromatherapy
Fresh air
Candles/insense
Comforting smells

Taste

Strong flavors
Warm drinks
Eat slowly
Nostalgic flavors

www.blessingmanifesting.com

Grounding Exercises

Hold a pillow, stuffed animal or a ball

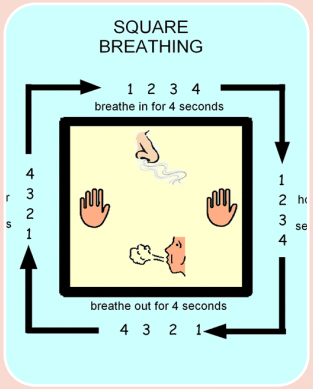
Place a cool cloth on your face, or hold something cool such as a can of soda

Listen to soothing music

Put your feet firmly on the ground

Focus on someone's voice or a neutral conversa-tion.

5-4-3-2-1 Game



Breathing

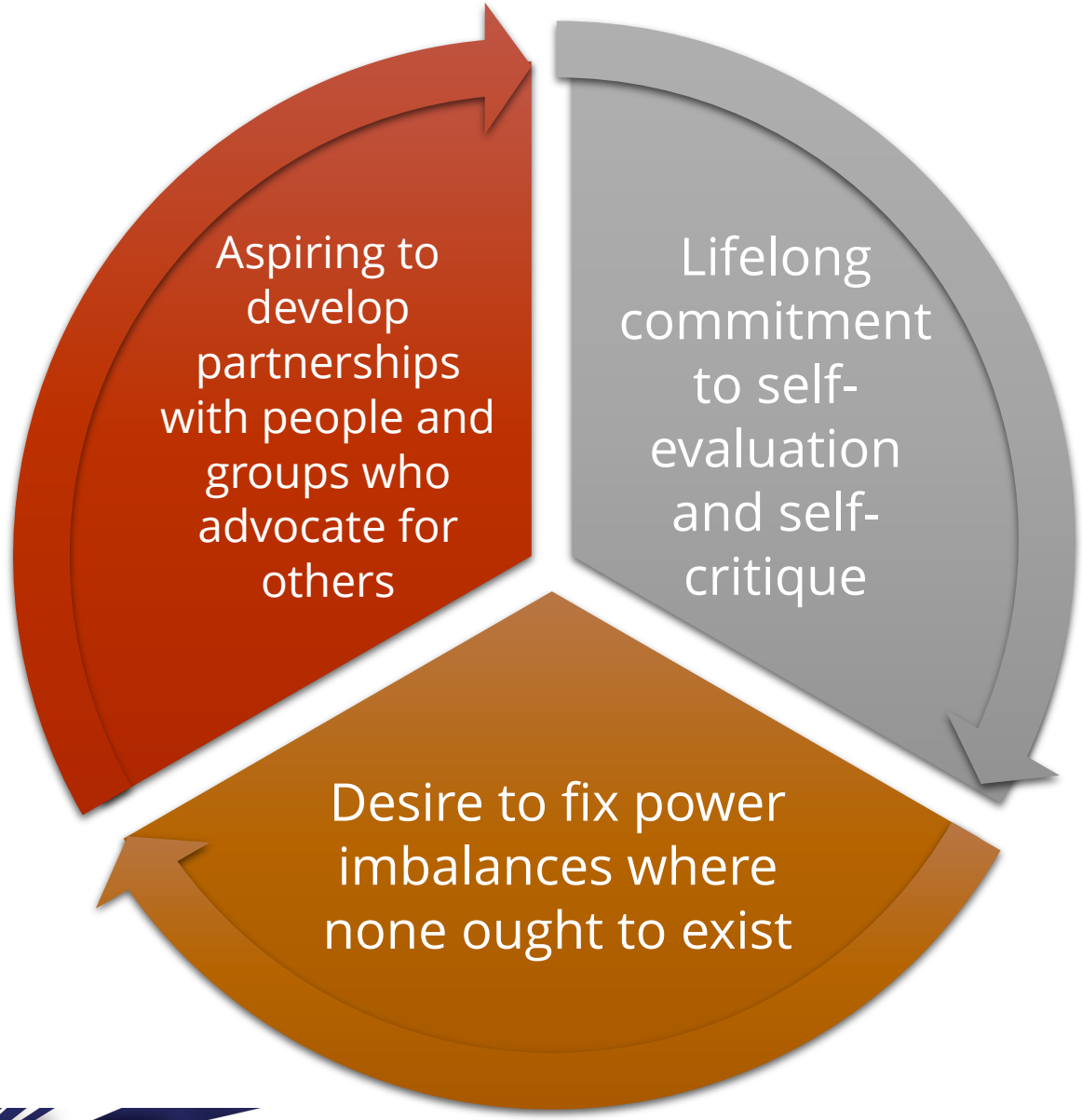
Stress Reduction Interventions

Diaphragmatic / Deep Breathing
Visualizations / Guided Imagery
Progressive Muscle relaxation
Meditation
Everyday ways to relax

Everyday Ways to Relax

Interactions and Communication

Attunement & Cultural Safety



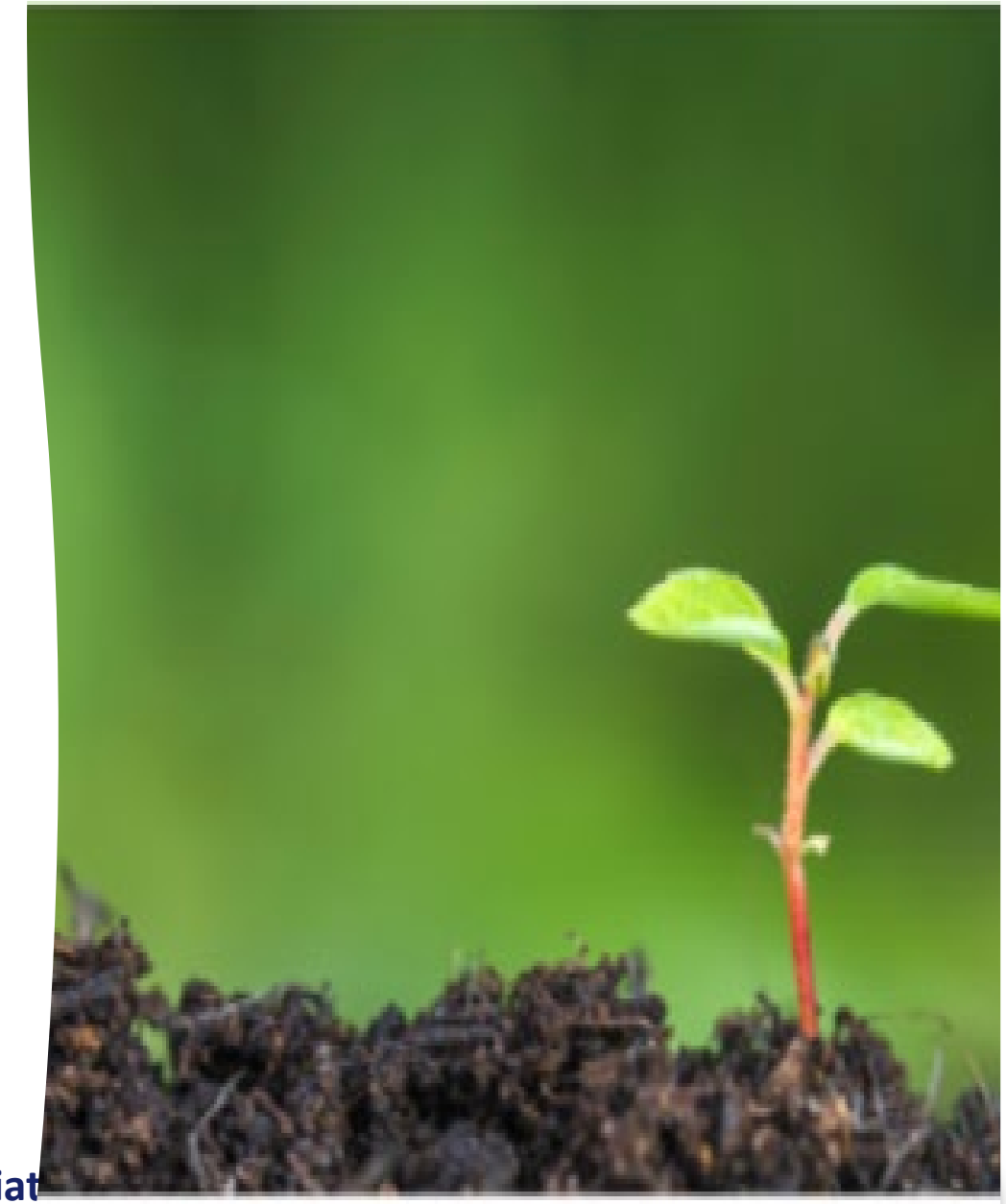
-Tervalon & Murray-Garcia, 1998

Cultural Humility is another way to understand and develop a process-oriented approach to competency.

> "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]"
>
> Hook et al, 2013

Be Attentive to Language - It Matters!

- Vocabulary reinforces feelings and beliefs
- Helps guide behavior
- Leads to greater options for acting
- Allows us to be able to recognize resilience in self/others

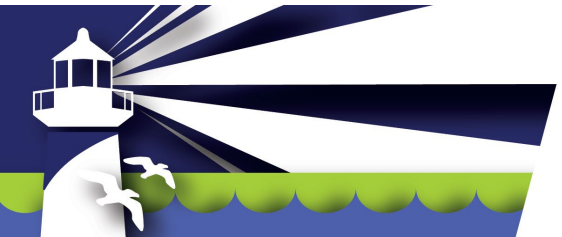


When Communicating…

- Use simple, clinical language
- Introduce and explain things and processes
- Ask permission
- Stay within eyesight
- Respect personal space
- Be efficient
- Discuss findings
- Ask for questions
- Express thanks

Non-Verbal Communication

- Appear engaged, pleasant and calm
- Maintain appropriate eye contact
- Remain at eye level with the person (when safe to do so) and at an angle
- Avoid sudden movements
- Keep hands outside of pockets and uncrossed
- Pay attention to cues (i.e., tensing muscles, fidgeting, breathing quickly, flushing, crying, trembling, appearing distracted or spaced out)



What is Active Listening

- A skill, developed over time and improved with practice
- Requires listening to understand, not listening to respond
- Includes listening with all your senses, being fully present in the conversation
- Includes active exploration and interest in what the speaker is sharing with you
- Conveys your investment in the relationship with the speaker

ıg and Conference
September 27–29

Responding to Emotionally Escalated Behavior

Stay Calm

Manage your own response

Identify a purpose to interactions

Avoid physical confrontation

Set safety limits

De-escalation Techniques

Employ	purposeful & thoughtful interactions, Person first language
Focus on	relationship building, Practice self-awareness
Promote	consistency & predictability
Teach	proactive regulation strategies
Recognize	areas of strength
Avoid	punitive and/or exclusionary practices
Foster	a safe space

Debriefing Escalation Events

WHY DEBRIEF ESCALATION EVENTS

WHO SHOULD DEBRIEF

METHODS OF DEBRIEFING

Avoid Sliming Others!

Practice Low-Impact Debriefing

- SELF A ESS
- FAIR
- C
- L MI E D DI LOSURE

Trauma-Informed Outcomes

- Involve the individual
- Help recognize the impact of actions
- Build individual's capacity
- Invest great energy, creativity and resources up-front
- Understand that behavior change is slow and incremental

Build Relationships

Honor voice and choice

Partner with people

Request feedback

Ensure comfort

“Keep the Human in Human Services”

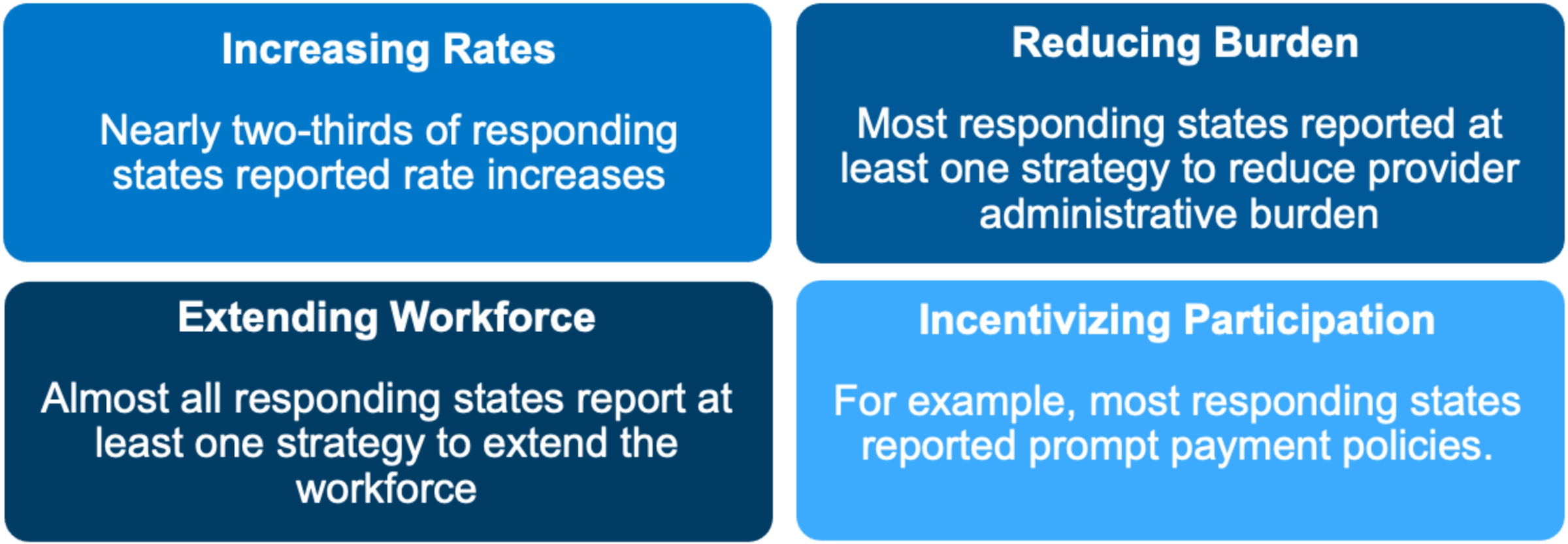
-Dr. Pat Deegan

Pulling it all together - creating an environment of:

- Safety
- Trustworthiness and Transparency
- Lived Experience and Peer Support
- Collaboration and Mutuality
- Empowerment, Voice and Choice
- Cultural, Historical and Gender Considerations

Figure 1

Key Medicaid Strategies to Address Behavioral Health Workforce Shortages in place or planned as of FY2022



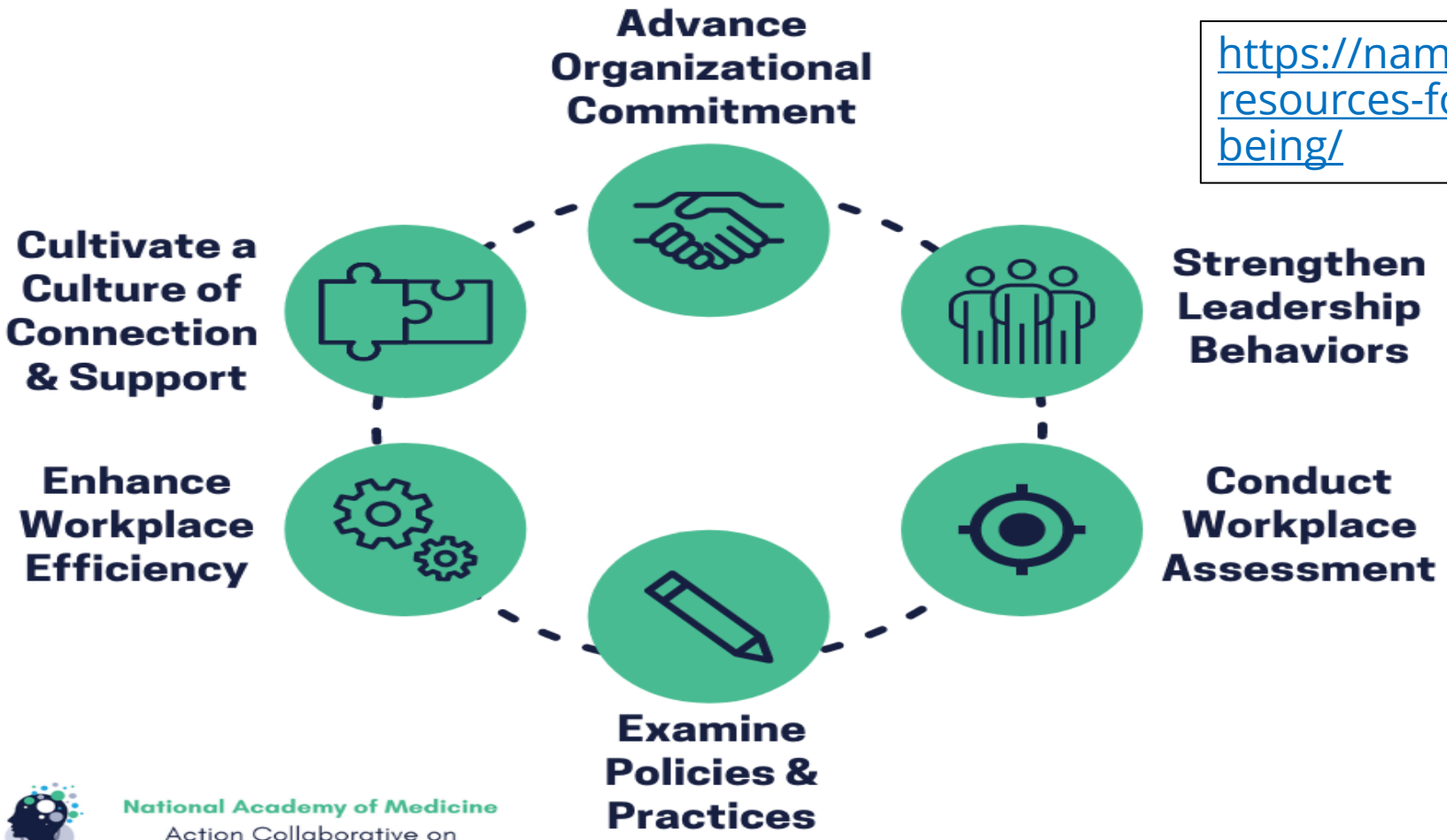
SOURCE: Behavioral health supplement to the annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022

KFF

Practice Transformation Strategies to Enhance the Workforce

1. Optimize clinical practice through integrated care models
2. Reduce burnout, improve team satisfaction and client outcomes through team-based care
3. Improve access to care through innovative solutions

Resources for Health Care Worker Well-Being: 6 Essential Elements



https://nam.edu/compendium-of-key-resources-for-improving-clinician-well-being/

National Academy of Medicine
Action Collaborative on Clinician Well-Being and Resilience

nam.edu/CW | #ClinicianWellBeing

Principles of Effective Integrated Care

Person-centered Multidisciplinary and Interprofessional Team Care

Population-Based Care

Measurement-Based Care

Evidence-Based Care

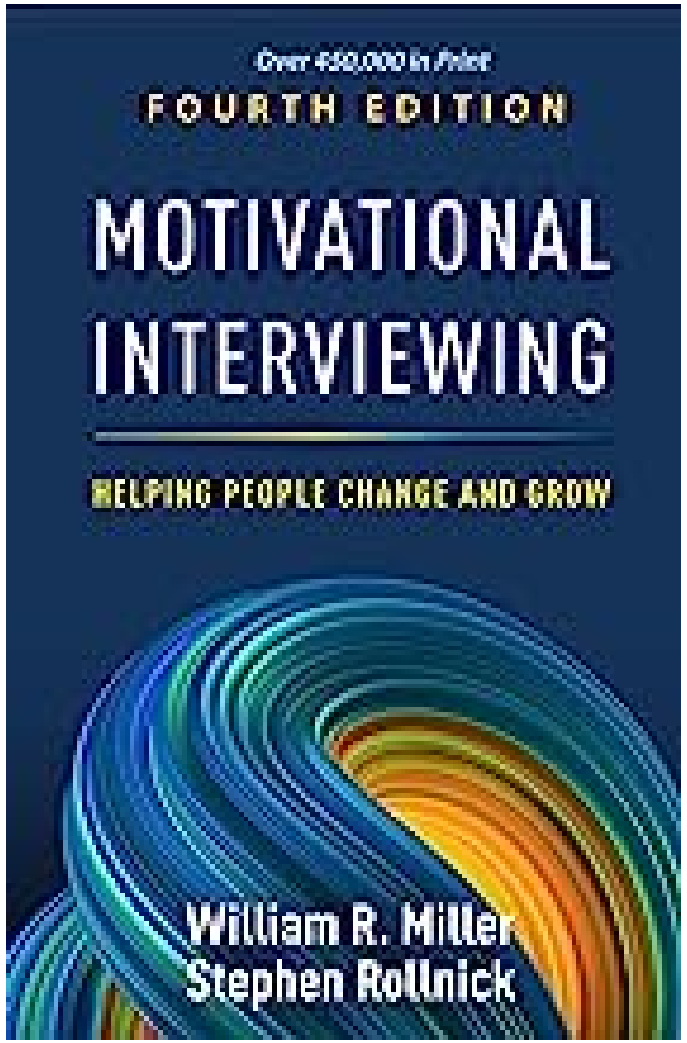
Accountable Care

- Evidence supports that team-based care has delivered:

» Increased **access** to care and reduced complications (Weller et al., 2014).

» Improved safety and better communication (Smith et al., 2018; Dehmer et al., 2016).

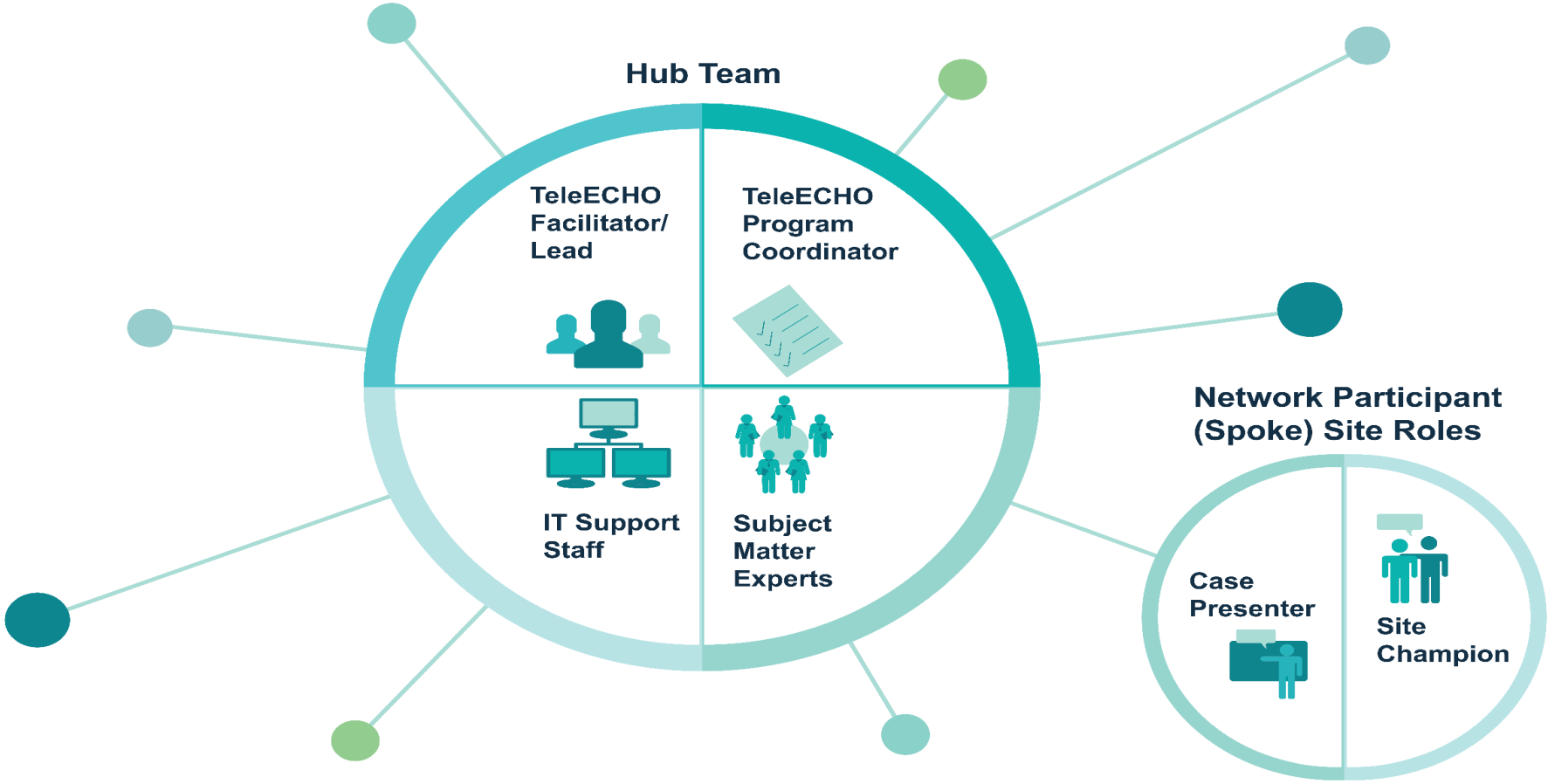
» Decreased burnout, turnover and tension and conflict among care providers (WHO, 2010), and increased **productivity** and **satisfaction** (Smith et al., 2018; von Peter et al., 2018).



Motivational Interviewing is…

a particular way of talking with people
about change and growth
to strengthen
their own motivation and commitment.

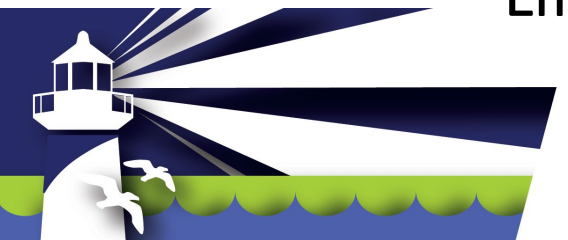
Extension for Community Healthcare Outcomes: Project ECHO Mission



https://wellsheadla.com/wp-content/uploads/2022/02/Diabetes-ECHO_-Introduction-What-is-ECHO.pdf

Policy Recommendations

Increase	compensation for high demand workforce
Support	adoption of transformative clinical approaches to relieve burden of increased demand
Expand	workforce through innovative approaches to building a behavioral health workforce pipeline
Reduce	administrative burden in documenting treatment plans through the use of person-centered documentation, collaborative documentation, and SOAP notes
Identify	opportunities to leverage innovative financing models for workforce such as career impact bonds (CIBs)
Increase	adoption of in-person/telehealth hybrid models and digital innovation
Lift	barriers and support extensions for telehealth access/options



Hope for the Future

- Investment in National Health Service Corps, Behavioral Health Workforce Education and Training Program
- Minority Fellowship Program
- Promotion of the mental well-being of frontline Healthcare workforce
- Launch of 988 crisis response and strengthen community-based crisis response
- Expanding tele/virtual options
- More health services for justice involved populations
- Focus on children and youth prevention (e.g., Schools)
- Use of MHFA to support professionals across the social and human service fields
- Expand funding and support

Center for Workforce Solutions

HMA

HEALTH MANAGEMENT ASSOCIATES

NATIONAL COUNCIL for Mental Wellbeing®

HEALTHY MINDS • STRONG COMMUNITIES

The College for Behavioral Health Leadership

USING COLLECTIVE IMPACT

Common Agenda
- Shared vision for change
- common understanding of the problems

Shared Measurement
- Collecting data and measuring results
- shared accountability

Mutually Reinforcing Activities
- Differentiated approaches
- Coordination through joint plan of action

Continuous Communication
- Consistent and open communication
- Focus on building trust

Backbone support
- Lead organization with role of support
- Resources and skills to convene and coordinate participating organizations

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THE CENTER FOR WORKFORCE SOLUTIONS WILL...

- Develop a steering committee to organize workforce efforts
- Facilitate process for identifying shared priorities, shared measurement of efforts
- Launch an ECHO learning collaborative with partners
- Organize and support subcommittees focused on shared workforce priorities:
  - Regulatory, Policy, Payment, Quality and Accountability, Clinical Model, Workforce Expansion (with focus on DEIB)
- Provide communication and connection between partners
- Develop a hub of resources on website to highlight innovative and scalable solutions
- Identify and seek funding to support a long-term collective effort

HEALTH MANAGEMENT ASSOCIATES

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DRAFT FRAMEWORK

HEALTH MANAGEMENT ASSOCIATES

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BREAK:

See you back in…

Open forum and Discussion

Subsession 4

4:00 – 5:30pm

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September 27–29

- Case and Care Management, Care Coordination, and Care Transitions
- Evidence-Based Practices
- Integrated Care Implementation and Practices
- Motivational Interviewing
- Screening, Brief Intervention, and Referral to Treatment for Substance Use
- Suicide Prevention, Intervention, and Postvention
- Trauma-Informed, Resilience-Oriented, Equity-Focused Systems and Approaches
- Workforce Development and Resiliency

And More!

Dr. Laura Leone, DSW, MSSW, LMSW

Consultant

National Council for Mental Wellbeing

LauraL@TheNationalCouncil.org

NATIONAL COUNCIL for Mental Wellbeing

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.

Annual Reach Goals: 50,000 individuals

Virginia Community Healthcare Association Annual Meeting and Conference
September 27–29

CoE-IHS Offerings:

Interested in an individual consultation with the CoE experts on integrated care?
Contact us through this form here!

ECHO and Learning Collaborative Opportunities

Live and On-demand webinars and trainings

Resources & Tools

Looking for free trainings and credits?
Check out integrated health trainings from Relias here

Subscribe for Center of Excellence Updates
Subscribe here

Tools & Resources

National Council for Mental Wellbeing

- The Comprehensive Healthcare Integration (CHI) 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

Tools & Resources

Integrated Care Assessment tools:

- Organizational Assessment Toolkit for Primary & Behavioral Health Care Integration (OATI)
- Integration Practice Assessment Tool (IPAT)

Integrated Care Financing:

- Integrated Care Financing Tools

Health Equity & Organizational Wellness:

- Advancing Health Equity in Integrated Care Toolkit
- Cultural Humility Scale
- Equity Climate Assessment

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