HRSA
Health Resources & Services Administration

Community of Practice (CoP): Supporting Behavioral Health Integration Into Your Health Center

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Vision: Healthy Communities, Healthy People

Welcome Back!!!!

Today's Agenda

- A quick check in
- Review of todays objectives
- Brief presentation: "The model that works best at my clinic." Guest presenter: Dr. Lora Peppard
- Discussion/Q&A
- Between-session activity
- Plus/Delta

Today's Learning Objectives

At the end of this session, participants will be able to:

- Identify the transtheoretical elements of integrated care
- Describe their population of focus for this COP, their needs and the intended outcomes
- Reflect on your completed ICRC assessment to identify your strengths and challenges providing integrated care for this population.
- Make progress toward defining the model that best fits
- Identify specific capacity building that will support your success
  - Staff buy in, increased staff knowledge and skills, common elements of a care plan, supportive technology to monitor and guide, workflow and staff roles

Today's Presentation

Building the Model That Works Best in My Clinic

Presenter: *Lora Elizabeth Peppard, Ph.D., D.N.P., PMHNP-BC,*
Deputy Director for Treatment & Prevention; Director, ADAPT Division, Washington/Baltimore HIDTA

What Are the Essential Ingredients?

Integrated care is “complex systems that have rich interconnectivity between parts that have irreversibly transformed each other.”

—Joel Hornberger, Cherokee Health

The patient is at the center of all planning and action

Behavioral Health Integration Models

	Collaborative Care	Primary Care Behavioral Health	Cherokee Integrated Care
KEY FEATURES:	BH care manager, consulting psychiatrist, registry, sometimes BI, systematic f/u	**Generalist** in nature, 15-30 min visits, **working right alongside the team** across variety of issues	Blended Stepped Model
GOAL:	Improve treatment response for select conditions, primarily depression and anxiety.	Broadly focused on improving care for the whole clinic population through brief consultation/education on biopsychosocial issues.	Both

Effective Behavioral Health Integration Features

	Collaborative Care	Primary Care Behavioral Health	Cherokee Integrated Care
EFFECTIVE BHI FEATURES			
Team-based Care (most important)	✓	✓	✓
Shared Population and Vision (Population Health Approach)	✓	✓	✓
Systematic Clinical Approach	✓	✓	✓
Continuous Quality Improvement and Measurement of Effectiveness	✓	✓	✓
Patient-Centered Care (shared care plans)	✓	✓	✓
Evidence-Based Care	✓	✓	✓
Accountable Care	✓	✓	✓
Practice Transformation Support	✓	✓	✓

Core Components and Tasks

	Collaborative Care	Primary Care Behavioral Health	Cherokee Integrated Care
CORE COMPONENTS & TASKS			
Informed Consent for Treatment	✓	✓	✓
Screening for Behavioral Health Needs	✓	✓	✓
Patient Identification & Diagnosis	✓	✓	✓
Engagement in Integrated Care Program	✓	✓	✓
Evidence-based Treatment	✓	✓	✓
Communication & Care Coordination	✓	✓	✓
Systematic FU, Treatment Adjustment, Relapse Prevention	✓	✓	✓
Case Review & Consultation	✓	✓	✓
Program Oversight & Quality Improvement	✓	✓	✓
Coordinate Gaps in Care	✓	✓	✓
Coordination between primary care and outside specialty mental health for severe BH needs	✓	✓	✓

Service Delivery

	Collaborative Care	Primary Care Behavioral Health	Cherokee Integrated Care
SERVICE DELIVERY			
BH Service Offerings	Screen, BT, RT	Screen, Early Intv, RT	Screen, Early Intv, BT, RT
Clinical Approach	Protocol driven	Clinician driven	Clinician driven
Risk Stratified Target	Mild, Moderate	Mild, Moderate	Mild, Moderate, Severe
Care Intensity	Moderate - High	Low	Low - High
Treatment Goals	Remission (treatment to target)	Improvement	Improvement
Treatment Duration	3-12 months	</=6 sessions	Varies
Patient Volume	Moderate	High	High

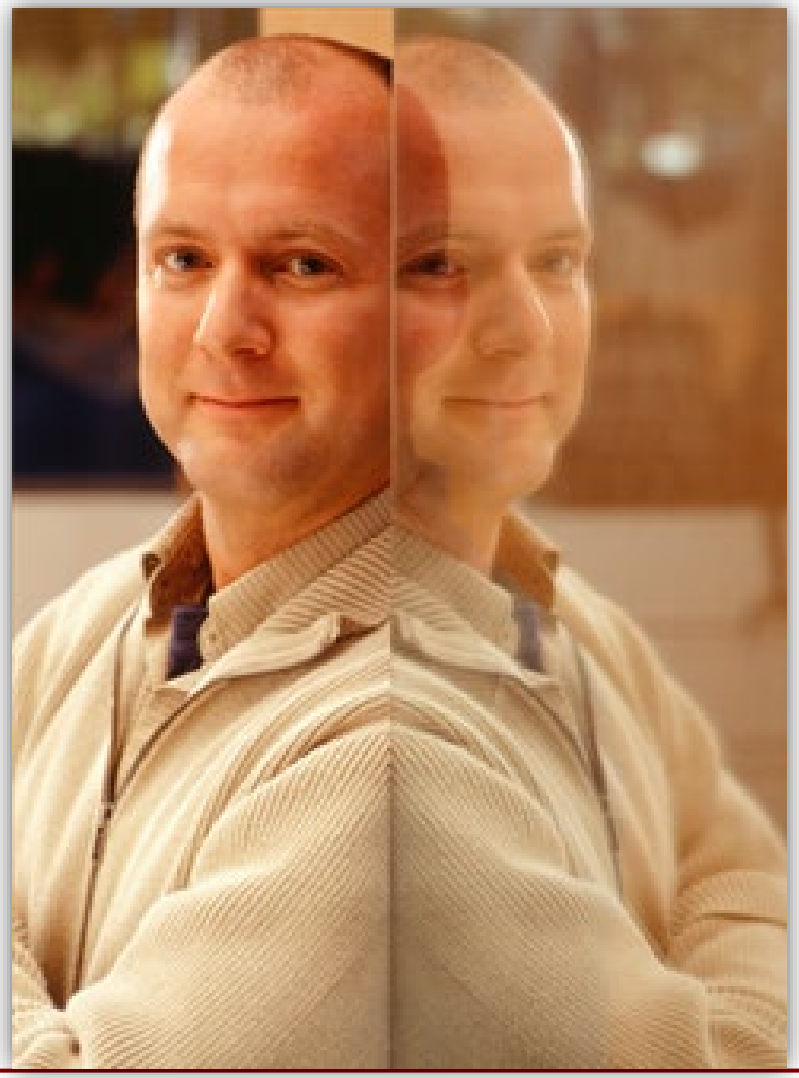
Distinguishing Features

	Collaborative Care	Primary Care Behavioral Health	Cherokee Integrated Care
Key BH function	Care mgr w/ BH training	Educator - Licensed BH specialist	Educator and Provider Licensed BH specialist
Emphasis	Disease-specific (MH) Depression, anxiety, substance use (more recently), problem solving therapy, medication treatment	Generalist (BH, MH, Wellness) Whole population	Generalist (BH, MH, Wellness) Whole population, behavioral health conditions
Target symptoms	Behavioral health	Biopsychosocial	Both
Accessibility of BH consultant/provider	Warm handoffs encouraged but may not always be accessible same day	Same day with warm handoffs, available for "consults"	Same day with warm handoffs but also available for "therapy"
Productivity	On average a 1:80 ratio for BHCM/patients	High patient volume	12 visits/day, 4:1 PCP/BHC ratio
Length of Visits	10-60 minutes for care management or psychotherapy	Brief: 10-30 minutes	Brief and coordinated therapy appts
Role of Psychiatry	Consultant (Provider)	(Consultant)	Consultant/ Provider
BH Service Offerings	Screen, BI, BT, RT	Screen, Early Intv, RT	Screen, Early Intv, BT, RT
Measurement-based Treatment to Target	Use of patient registry for tracking and systematic f/u	Measurement and reporting on clinical outcomes varies and often not required by BHC - rather, captured through PCP	Patient Dashboard
Infrastructure for MAT or SUD Treatment	Yes	No	Yes
Other Features	Systematic FU, Defined discharge based on goals	Consultant approach; primary consumer is PCP; shared tx plan	Face sheet, Consultant + Specialty MH; Shared tx plan

Key Considerations

1. All models represent a culture of whole health.
   - The big ask is all of the organizational behaviors that will need to change.
   - Retraining, remapping, and resetting the north star.
   - Implementation issues cut across all models.
2. Models guide the development of the workforce into their professional identity beyond the training they received during their education. They are the training wheels.
   - Not every behavioral health professional will be a good fit for your model.
3. First step: Define what you are currently doing.
4. Next step: Which model best aligns with the strategic plan for your organization?

Open Discussion



Between-Session Activities

1. **Confirm** your **priority population** for this integrated care CoP.

   - General population: e.g., children, adults, seniors
   - Targeted population(s): e.g., adults with chronic health conditions, such as diabetes, cardiovascular, respiratory, chronic pain, or depression; veterans; adults with SUD/opioid use disorder; racial and ethnic minorities; others

2. **Identify** what **data** you have available for your priority population.

Reflecting on Today: Plus/Delta

- + What worked for you today?
- △ What would you change?

BPHC-BHTA Technical Assistance Portal

https://bphc-ta.jbsinternational.com/

- Request Technical Assistance
- Access Learning Management System (LMS) Modules
- Learn more about BH TA Options
  - One-on-one Coaching
  - E-learning Webinars
  - Strategies for Community Outreach
  - Virtual Site Visits
  - Community of Practice (CoP)

Weekly Office Hours During the CoP

What are office hours?

An opportunity to:

- Dive deeper into a topic area
- Better clarify needs and plans

CoP Satisfaction Assessment

- Please complete a satisfaction assessment of today's session.
- If you plan to obtain CEUs for your time in this CoP, the satisfaction assessment is required.
- There are two ways navigate to the assessment:
  1. Follow the link provided in the chat here
  2. You will be emailed a link from us via Alchemer, our survey platform

Thank You.

See you next week!

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