

# Colorado State Innovation Model (SIM) Project

## Health Care Provider Workgroup

July 12, 2013

### Overview

The big job of integrating physical and behavioral health care must start somewhere – with one behavioral provider on staff, perhaps. Integration must be manageable for health care providers, with specific goals, ongoing training programs and clear measurements of progress. It must be communicated effectively to patients. And payment models must support the flexibility needed to make integration happen.

These were overarching themes identified by a group of health care providers meeting to contribute expertise to the Colorado Health Care Innovation Plan, which focuses on integrating physical and behavioral health care in Colorado.

At the foundation of the recommendations, however, was a recognition that integration is an important part of creating a system that delivers great care at more sustainable costs.

### Summary

The provider stakeholder group focused its conversation on establishing a common framework for behavioral and physical health integration in a health care setting.

The dialogue spanned integration implementation issues such as clinical culture change, time and practice management techniques to incorporate behavioral and

### About This Report

The second of three meetings of stakeholders representing health care providers across Colorado met on July 12, 2013. Attendees included 24 providers as well as representatives from the SIM project management team. The group made 15 formal recommendations related to integrating physical and behavioral health, Colorado's proposed health care innovation plan, workforce education and state and federal policy updates.

physical exam needs, clinical protocols and screening tools for behavioral health concerns, staffing and training.

The group coalesced around several important drivers of physical and behavioral health integration, agreeing that:

- Integrating behavioral health with primary care is an important and critical step in the delivery of quality health care.
- Each clinic should assess its patient population to determine the appropriate capacity of behavioral health integration necessary to best meet patient needs.
- All clinics should establish a “no wrong door” approach for behavioral health needs, whether those needs are best addressed in-house or through

an integrated specialty program outside of the primary care setting.

- Behavioral health integration should start with a base investment of one behavioral health provider per clinic or practice. Capacity can be evaluated and expanded over time, if needed, once there is a strong start.
- Sharing successful approaches to cross-training and coaching health care personnel to work together with a shared patient population and workspace will be important. Sharing developed and tested time management and clinical protocols as well as

patient screening tools will be useful to all involved.

The discussion also raised crucial policy and financing questions to consider as integration moves forward. A common concern is ensuring that academic accreditation rules promote the ability of medical and behavioral health care students to learning together and build the foundation of teamwork throughout their education. Another common concern is bringing the health care payment system into alignment with integration, recognizing the importance of paying for behavioral health interventions alongside physical health care.

## Review of SIM Project, Vision and Goal – First Meeting Report:

Stakeholders reviewed and approved the report from the first meeting, which included 15 recommendations for health care innovation.

### ***The Colorado Framework: Integrating Primary Care and Behavioral Health***

Participants received a briefing on the proposed framework for behavioral and physical health integration from Dr. Benjamin Miller, Barbara Martin, and Carissa Kinman of the Family Medicine Department at the University of Colorado School of Medicine. The framework is intended to establish a common understanding for providers and policymakers across the state regarding the core functions, components and capacity considerations that each clinic or practice would use to plan and execute an integrated care model.

The physical and behavioral health integration framework is built on three supporting pillars:

- Integrated care teams
- Shared patient population and mission
- Supporting infrastructure.

These components must be in place for successful integration. The integrated team requires recruitment, training and team building. The shared population and mission focuses the team on a mutual responsibility

for a panel of patients with the goal of addressing the behavioral and physical needs presented by all of them. The supporting infrastructure includes systematic methods for assessments, time management, clinical protocols, follow-up, communication between care provider, the patient and the family, and coordination of care.

### ***Framework Discussion and Recommendations:***

**Recommendation 1:** Clarify the “tiers” concept to better capture that the integration capacity of each clinic or practice, which was labeled as Tier 1, Tier 2 or Tier 3, is based on the specific behavioral health needs of the patient population. Some clinic or practices may not need to recruit and build shared capacity to treat the most complex behavioral and physical health cases if they have few patients with those needs.

**Recommendation 2:** Further define the expectations of integration when developing ‘in-house’ capacity for a small subset of more serious, long-term behavioral health needs are present. What do referral systems look like that still ensure shared mission and health outcomes as well as strong communication and coordination?

**Recommendation 3:** Include the “minimal data set” in the framework and clarify how it will relate to ongoing data collection.

For most of the stakeholders, this was the first presentation they had received of the framework concept. Participants raised clarifying questions and offered suggestions for refining the framework to ease comprehension. The most common question was whether integration capacity was focused on the practice or the group of patients and whether it was considered “better” to have a Tier 3 level of integration as opposed to a Tier 1 level of integration. Dr. Miller clarified that the intent is for practices to develop a level of integration that meets the needs of the majority of their patients. Identifying the behavioral health needs of the majority of patients may require baseline assessments and ongoing monitoring, he said.

The discussion also focused on the metrics for integration and how to measure the capacity outlined in the three tiers of the proposed integration framework. A high-level description of the minimal data set needed for integration was presented, with the understanding that the intent is not to increase the data capture and reporting burden of clinics or practices. This data set could be a topic of further conversation with this stakeholder group.

Several important clarifications regarding the framework were broadly agreed to by the group, including that:

- Persons suffering from Serious and Persistent Mental Illness (SPMI) are not the target for broad-based, state-wide clinical integration of primary care and physical health. The needs of these patients will often exceed even the highest capacity of a clinic.
- Clinics or practices need to develop the capacity that meets the needs of the vast majority of their patients. However, all clinics should develop at least the basic capacity in light of data showing that most patients enter the primary care system with behavioral health needs.
- The framework is a tool to build collective understanding of care integration and sets out baseline requirements for building an integrated care model.

## ***Achieving the SIM Goal - Reaching 80 Percent of the Colorado Population***

**Recommendation 4:** Clarify that the SIM goal means that 80 percent of Colorado’s population has access to a primary care practice that has at least the basic level of behavioral and physical health capacity.

**Recommendation 5:** Consider the role of public health and community-level health care integration work as an element of measuring integration against the SIM goal.

The goal of the Colorado Health Care Innovation Plan is: By 2019, 80 percent of Coloradans will have a comprehensive primary care home that integrates physical and behavioral health.

Stakeholders discussed how the proposed integration framework related to the stated goal of the Innovation Plan. Participants came together around the idea that, in practice, measuring achievement of the goal would mean that 80 percent of the population has access to a primary care practice that has at least the basic level of integrated behavioral and physical health care identified in the framework.

Even though there was broad agreement on the goal, there are questions about the role of public health and community-level behavioral health integration in contributing to the health care innovation plan goal. The group agreed to focus its efforts on the clinical health care setting, but noted the importance of addressing integration beyond clinic walls.

The group affirmed the importance of addressing behavioral health issues more comprehensively. Many noted that doing so in a primary care setting is likely to be a much more effective approach, flowing from coordinated and timelier care as well as a lessening of the stigma of receiving behavioral health care by receiving it in a primary health care setting. Several participants noted that, especially in small towns, it is difficult to visit a clinic specifically for mental health without other residents knowing.

## Case Studies – Integration in Colorado

Two case studies were highlighted during the meeting – Salud Clinics and AF Williams. These clinics shared examples of screening tools, workflows and time management systems.

### • Salud Clinics:

Dr. Tillman Farley, Medical Director, shared the approach of Salud Clinics to integration. Each of the nine Salud clinics integrates behavioral and physical health in the primary care setting and often integrates other types of care, such as dental and pharmacy, to create a “one-stop shopping” experience for patients. Dr. Farley said that he was convinced of the need for integrated care by studies that found at least 85 percent of clients with behavioral health needs were not attending referred appointments to behavioral health clinics.

He said that all of Salud’s patients need access to behavioral health services, whether preventive in nature or for serious and persistent mental illness. Behavioral Health providers are considered full primary care providers and are co-located in the primary care setting.

Behavioralists see each new patient, every OB patient and every patient with a high likelihood of need, including those with headaches, stomachaches and diabetes.

The protocols created by Salud to ensure integration include:

- Behavioralists and physicians work in tandem in examining room.
  - Initial medical screening, including blood pressure, weight and height.
  - Behavioralist comes in and screens for depression, among other things such as anxiety, trauma, tobacco, alcohol and drugs. If any of those screens are positive, the behavioralist digs deeper with screening. Each patient is placed on a psychosocial need scale.
- Behavioral health screening usually lasts about 10 minutes, but sometimes takes longer. The goal is to get access to all patients expected to need it. Usually, there is an effort to do between 10 and 12 screenings a day plus a few longer sessions.

- Behavioralists invite patients to call for an appointment, if appropriate. Or, the behavioralist can see the patient the next time they come in for a physical health appointment.
- Each provider takes as much time with the patient as needed to address health concerns.
- Behavioralists generally do not see a patient more than five times, focusing on a solutions-oriented model to move the patient forward rather than analyzing the factors contributing to the patient’s behavioral health problems.

### Salud’s integrated team includes:

- Masters degree level providers and doctorate level providers. If a patient needs more intervention than that offered by the medical doctor and the masters level behavioral provider, then a doctorate level provider sees the patient.
- Financial constraints govern hiring decisions, requiring trade-offs to ensure comprehensive integrated care.
- SPMI patients should most likely be seen by psychiatrists in a mental health setting, not in the primary care setting.
- The behavioral health providers are encouraged to develop a comfort level with seeing children.

### • A.F. Williams – Family Medical Center:

Dr. Carol Odell, a primary care physician, and Dr. Sandra Brown Levey, a post-doctoral in psychiatry, shared the model of integrated care developed over the past 10 years at A.F. Williams. A.F. Williams is a level three National Committee for Quality Assurance (NCQA) recognized patient-centered medical home and operates as an urban university-based training clinic. Their care team includes physicians, mid-level providers, licensed psychologists, pharmacists, nurses, medical assistants, care team assistants, care team supervisor, a practice manager.

### The protocols created by A.F. Williams to ensure integration include:

- Using a written Adult Well Being screening tool clinic-wide. This tool is designed to see where patients fall in behavioral health and mental health needs and helps speed up visits by identifying

baseline information, targeting additional questions and indicating whether a behavioral health provider is needed during the visit.

- Balancing immediate access and treatment time. This generally requires referring patients with long-term treatment needs to other providers. Patients are told that any care required after four to six visits will be provided in a different setting and that the clinic will connect them to that care.

#### **A.F. Williams' integrated team includes:**

- At least one behavioral health provider in the practice. This is not perfect capacity, but it means a primary care provider can often run down the hall and ask a question of a behavioral health expert. Usually this would be a psychologist or a post-doctoral student.

## **Clinical Integration Implementation**

**Recommendation 6:** Consider development of a state-wide "Get One" Integrated Care Campaign to educate, coach and share the tools for on-boarding at least one behavioral health specialist in primary care practices.

**Recommendation 7:** Share developed and tested protocols for referring long-term or severe behavioral health needs of the subset of patients that will exceed the integrated capacity of the clinic.

**Recommendation 8:** Identify and share curricula for training and team-building that are proven to help create a shared mission, acceptance of core competencies for each team member and the development of shared workflows and space arrangements.

Implementing a model of integrated care is a process of assessment, development and refinement. That process must start somewhere. The group was enthusiastic about the idea of pushing clinics or practices to start integrating care by bringing at least one behavioral health specialist into the primary care setting. This idea was often referred to as the "Get One" campaign and was intended to break through the inertia of planning and financing concerns that can stop innovation before it starts.

This push would come with support. The group acknowledged the usefulness of sharing protocols that integrated care models that have already been

developed and tested in a clinical setting. They said that the screening tools, workflows and time management systems created successfully by Salud Clinics and A.F. Williams could be brought together into a shared toolkit. The group would also like to see protocols that successfully address needs of patients that are greater than the integrated capacity of the primary care clinic while maintaining well-coordinated care.

Stakeholders said that one of the issues that must be addressed is creating a culture of integration from the top down in clinics and providing training and team-building that breaks down professional barriers. Patients must be seen as "our patients."

The discussion of culture change and team-based care brought out several points:

- The tone at the top must support integration and establish an expectation that the staff will work as a team to provide excellent care to the population.
- The practice must invest in ongoing training and team-building.
- It will be crucial for managers to address unacceptable staff interactions that prohibit team communication or limit the time spent with patients.
- Budget trade-offs will be required to prioritize the integrated care model.
- Staff recruitment efforts should be focused on personnel who understand that behavioral health care in a primary care setting is not intended to include 50- to 60-minute therapy sessions.

Payment reform is a crucial component of implementing care integration, this group said, including the need to for a sustainable funding model. It was also acknowledge that integrating behavioral and physical health is necessary but not sufficient, and that this effort could lead to advances in integration of oral health, pharmacy, and other common health needs.

## **Integrated Care in Rural Areas**

**Recommendation 9:** Develop case studies of integrated care in rural settings that exhibit solutions to recruitment, co-location, clinic competition and remote supervision. One example might be the integrated rural clinics in Cortez.

**Recommendation 10:** Facilitate rural community conversations on integrating care. Part of the conversation should focus on competition concerns and distance medicine strategies.

Participants agreed that integrated care is essential in rural areas, both to address the stigma and to make the most of finite resources. However, in order to make integration work, rural communities will need to be creative with staffing and supervision arrangements, including telemedicine, use of interns, distance supervision and distance education.

Rural communities may have primary care clinics and mental health clinic that will see integration as a competitive concern, worried that they will lose patients and funding. The participants agreed that these communities need to look for opportunities to create “co-operation.” Discussions could be facilitated to look at overlap between patients and mission and where there are also unique functions.

## ***State-wide Infrastructure - Education, Data, and Policy Implementation Considerations***

**Recommendation 11:** Identify successful workforce training programs that support integration – both in formal professional education systems and informal continuing education modules.

**Recommendation 12:** Facilitate roundtables between integrated health care clinic administrators and educational programs to discuss staff core skills and curriculum.

**Recommendation 13:** Outline the data necessary for integrated care program evaluation and assess if or how that data can be captured from existing sources.

**Recommendation 14:** Review state scope of practice rules for psychiatric nurse practitioners to see if they should be expanded to include physical exams.

**Recommendation 15:** In payment reform discussions, stress rationalizing state or private payer billing requirements so that it is about the care.

Integrating physical and behavioral care in a clinic requires a clinical infrastructure that supports the work. Supporting integration at a state level will also require supporting infrastructure that may include changes in formal education or training programs for health care

professionals, altering regulations that can prohibit information sharing and establishing baseline data requirements for evaluating integration and creating a center for tools, resources, team-building and training.

## ***Education***

The stakeholders acknowledged that current national exams and accreditation standards have not caught up with team-based care and integrated health care models. Often, psychological education exams are geared toward traditional, historical models of care devoted to long therapy sessions in closed-door settings. The group agreed that such standards are not facilitating integrated care, but also that they may be beyond the scope of Colorado’s challenge to innovate.

Additional professional training barriers were recognized by the group. Some participants noted that integrated post-doctoral training is one approach, but said they have seen mixed success with retention in an integrated setting. Others noted that students may be trained in integrated care but may not be able find receptor sites. And, as often heard, the issue of payment is a barrier to bringing behavioral health students into primary care.

There are professional education programs that are moving toward integration that could serve as models for health professional schools in Colorado if they are not already doing something similar. For example, the University of Colorado School of Dental Medicine is adhering to competencies that are reflected in accreditation agencies while also including core competencies for team function and communication.

There was general consensus that training and team-building outside of the formal education system will be necessary to prepare the workforce and that successful training models need to be identified. It was suggested that clinic administrators work with the education system to identify core skills that graduates need for such a system and discuss options for developing curriculum.

## ***Data and Information***

The Colorado Health Care Innovation Plan establishes a goal for the state that is grounded in research that has found that integrating physical and behavioral care in one setting is good for health. In addition, practitioners

know from experience that bringing these health needs together is the right thing to do for patients and leads to better outcomes. However, such health outcomes are hard to measure. The group discussed the merits of spending significant resources in measurement systems for integration. There was general agreement that any measures at the clinical level should not burden providers and possibly serve as a roadblock to change.

The group suggested that some of the most important data components of an integration effort would provide support to:

- Seamlessly integrate electronic behavioral health and primary care records – either interoperable or as one shared system – and address concerns about HIPAA.
- Improve behavioral health in short five- to six-session increments. Not all needs require long-term therapy.
- Create common approaches to integrated care program evaluations.
- Allow clinics or providers to break down their shared patient panels and assess how they are doing at screening for anxiety, depression and other behavioral health concerns as well as how they are doing at addressing behavioral health among diabetics or other common disease groups.

AF Williams uses a tool called EPIC, which breaks down quantifiable information and behavioral health-specific metrics.

## **Policy**

The bureaucratic silos, layered behavioral health and primary care regulations and policy requirements, and divided funding streams were all discussed and documented during the first meeting of this group. These are strong concerns.

This conversation focused on whether there are scopes of practice issues that are barriers to integration. The group acknowledged that the number of care professions and subsequent billing rules make for an almost impenetrable maze. If Colorado could streamline and justify billing policies to support and enhance integration, it would serve this effort well.

## **Accelerating Integration – Investing Finite Resources To Affect Change?**

Stakeholders were asked to consider how the state could best use a finite grant to create an integration movement. Initial suggestions included:

- Gathering clinical tools and training modules that can be used across the state
- Providing start-up funding for clinics to hire staff, train, and develop infrastructure
- Leveraging resources with state and local foundations.
- Creating an education campaign for workforce and clinic administrators – selling the framework and convincing folks it is the right thing to do
- Funding ongoing projects that they incorporate or advance integration

## **Conclusion**

The meeting closed with a reminder to provide additional feedback by registering on the ColoradoSIM.org website. The website offers a forum for sharing additional examples and continuing the dialogue of these meetings.

The final SIM provider stakeholder meeting is scheduled for August 15, 2013, from 9 a.m. to noon. The group will review recommendations from the first two meetings and discuss how to use those recommendations to develop an action plan for implementing the Colorado Health Care Innovation Plan.

# Appendix A: Participation List

**Michael Rice**, *Center on Nursing Excellence, University of Colorado Anschutz*

**Jack Westfall**, *Colorado HealthOP*

**Donald Moore**, *Pueblo Community Health Center*

**Michelle Mills**, *Colorado Rural Health Center*

**Alfonzo Payne**, *Valley-Wide Health Systems, Inc.*

**Michael Lott-Maries**, *Mental Health America of Colorado*

**Stacey Moody**, *Colorado Association for School-Based Health Care (CASBHC)*

**Colleen Church**, *Caring for Colorado Foundation*

**Dianne Brunson**, *CU Denver School of Dental Medicine*

**Peggy Hill**, *Colorado Behavioral Healthcare Council*

**Harriet Hall**, *Jefferson Center for Mental Health*

**Carol Saylor**, *Rocky Mountain Youth Clinics*

**Kristin Paulson**, *Center for Improving Value in Health Care (CIVHC)*

**Ben Miller**, *Office of Integrated Healthcare Research and Policy, CU Denver School of Medicine,  
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**Barbara Martin**, *Office of Integrated Healthcare Research and Policy, CU Denver School of Medicine,  
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**Anna Vigran**, *Colorado Health Institute*

**Deborah Goeken**, *Colorado Health Institute*

**Michele Lueck**, *Colorado Health Institute*

**Rebecca Alderfer**, *Colorado Health Institute*

**Moe Keller**, *Mental Health America of Colorado*

**Alexandria Gerace**, *HCPF*

**Judith Emery**, *Colorado Urban Workforce Alliance*

**Tanya Weinberg**, *Colorado Health Foundation*

**Katie Jacobson**, *Colorado Community Health Network*

**Marjie Harbrecht**, *Health Teamworks*

**Brooke Powers**, *ClinicNet*

**Ruth Benton**, *New West Physicians*

**Tillman Farley**, *Salud Family Health Centers*

**Shandra Levey**, *A.F. Williams Family Medicine Center*

**Carol Odell**, *A.F. Williams Family Medicine Center*