Behavioral Health Integration Learning Collaborative
Call for Participation

Background

- About half of Americans will experience some kind of diagnosable mental disorder in their lifetime. Lifetime prevalence of anxiety disorders in the United States is just under 30%, with lifetime prevalence of mood disorders at just under 20%, and substance use disorders at just under 15%.[1]
- Individuals with mental illness have a two- to four-fold increased risk of premature mortality; those with more severe illness may die 25 years earlier than the general population.[2]
- Mental illness and poor health are linked, with two-thirds of patients with mental illness having a co-occurring medical condition and nearly a third of those with a medical condition have a co-occurring mental illness.[3]
- The research tells us what providers and patients experience on a daily basis—25 to 30% of visits for primary medical care either originate from or have a significant related mental or behavioral health component.[4,5]

Project Description

The NH Citizens Health Initiative Behavioral Health Integration Learning Collaborative (BHI LC) will focus on the integration of behavioral health into the primary care setting with a focus on depression, anxiety, and substance use disorders as they present in primary care. The learning collaborative will consist of two cohorts (pending funding for second cohort):

- Cohort I: November 2015 – September 2016.
- Cohort II: September 2016 – June 2017. *Cohort I participants may choose to continue further work with the project and new participants will be welcomed to join as Cohort II. (Pending funding.)*

Learning Collaborartive activities will include:

- In-person, webinar and phone conference calls for learning content, information and data sharing, and peer support. Content will include, but not limited to:
    - BHI models
    - Workforce
    - HIT Integration
    - Connecting to community
    - Payment, Contractual and Financial
    - BHI for diverse populations
    - Using data and measures to track outcomes
- Quality Improvement (QI) Projects. Targeted Quality Improvement (QI) predicts using Plan-Do-Study-Act (PDSA) quality improvement cycles appropriate to the level of integration implementation. Content will be designed to be relevant and actionable for participants at various stages of integration.
- Practices will report EMR data monthly on selected measures on practice screening, behavioral and physical health outcomes and track their progress.

Project Goals and Outcomes

- Advance the status of participating organizations on the continuum of primary care behavioral health integration.
- Develop sustainable payment models to support the practice of integrated care.
- Demonstrate improvement on key quality and cost measures, using EMR reporting tools and claims-based analytic reports.

Project Collaborators

- **New Hampshire Citizen's Health Initiative (Initiative)**, staffed through the UNH Institute for Health Policy and Practice (IHPP), is a multi-stakeholder collaborative effort working for a health and health care system with better health, better care, and lower costs for all New Hampshire residents. The Initiative and its NH Accountable Care Project (NHACP) Learning Network will work to bring together the necessary content and infrastructure for the BHI LC, including the NHACP reporting suite.
- **New Hampshire and New England Integrated Care Learning Collaborative:** Led by Bill Gunn, Steve Arnault, and Judy Steinberg, these interlocking learning collaboratives will provide connections, expertise and providers at various stages of integration to assist in developing content, recruiting provider partners, and communicating with the field.
- **NH Center for Excellence (CfEx)** is a resource center for best practices in alcohol and drug services in New Hampshire. CfEx provides practitioners and providers with tools, resources, training information, and data to support their practices. CfEx is an initiative of the NH Department of Health and Human Services' Bureau of Drug and Alcohol Services and is funded in part by the US Substance Abuse and Mental Health Services Administration (SAMHSA), the NH Governor's Commission on Alcohol and Other Drug Prevention, Intervention and Treatment, and the NH Charitable Foundation. CfEx will provide SAMHSA-certified SBIRT trainers to lead sessions on SUD screening, referral, and treatment in primary care.
- **NH Pediatric Improvement Partnership:** The NH Pediatric Improvement Partnership brings together pediatric and family practice providers to develop quality improvement projects to improve identified quality indicators at the practice level. Current work includes improving developmental screening rates and access to specialized service for genetic conditions and seizure disorders.

Benefits of Participation

- Learn evidence-based behavioral health integration practices targeted to stages of integration.
- Receive tools, trainings, technical and quality improvement support to aid in implementation.
- Collaborate with providers, payers and other stakeholders throughout the state to implement best practices and together develop sustainable payment models.
- Access to the NH Accountable Care Project's Report Suite, which includes:
  - *Claims-based analytic reports*, driven by the NH Comprehensive Health Information System (NHCHIS) data, providing population, cost and utilization measures for both patients attributed to primary care and for patients attributed to having behavioral health services. The full report suite includes data for Commercial, Medicaid, and Medicare populations.
  - *Electronic Medical Record (EMR) quality report*, based on self-reported data from participating organizations. The aggregated median rates report provides a benchmark for comparison around key quality measures.
- Potential to receive CME.
- Reporting, benchmarking and feedback from peers throughout the state.

Learning Collaborative Overview

Learning Collaborative Participation Expectations

In order for the Learning Collaborative to be successful and work well for all of the participants, all participants are expected to agree to the following core principles.

- All practice and payer teams will have high-level commitment from the leadership of their organizations, including CEOs, CIO, and CMO as appropriate.
- All participants must sign Non-Disclosure Agreements (NDA) to participate in shared data conversations.
- Participating practices/systems must have Electronic Medical Record (EMR) in place in primary care practices.
- Maintain consistent participation/team representation for in person and web/audio conference sessions and annual symposium.
- Enjoy meaningful participation in collaborative discussions and learning.
- Participate in sharing learning in webinars/discussions as appropriate.

All participants (practices/systems, payers and other stakeholders) joining the learning collaborative will sign a Letter of Commitment demonstrating their understanding of and commitment to the Behavioral Health Integration Learning Collaborative. In addition, participants will be expected to sign a Non-Disclosure Agreement to protecting the confidentiality of the cost, quality and service volume data made available through the Accountable Care Project reporting suite to the participants of the Behavioral Health Integration Learning Collaborative.

Teams and Participants

Clinical Practice Participant, Teams and Roles

Each participating practice/ health system will identify a team to spearhead their clinical system and process change effort to implement evidence-based standards for integrating behavioral health care into primary care in their practice. We recognize that not all members of the team will be able to attend every BHI LC session; however, teams should assure representation by at least 2-3 members at each session and continuity of information flow for the team. Practice teams, at minimum, should include:

Team Member	Role
Team Leader (can be any clinic staff person)	• Serve as Clinic contact to the Learning Collaborative staff • Coordinate team effort to institute change processes • Ensure evaluation data/reports are submitted
Clinical Leader (MD, DO, NP, PA)	• Encourage & facilitate PCP involvement • Provide PCP perspective/insight
Nurse Leader	• Encourage & facilitate nursing staff involvement • Provide nurse perspective/insight

Behavioral Health Lead (for practices with current service)	• Provide BH clinical perspective • Provide insight BH integration
Information Technology (IT) Lead	• Assist with changes in IT infrastructure required to support clinic implementation of work flow changes • Work with IHPP staff to facilitate EMR extractions for evaluation purposes
Practice Management Staff Lead	• Encourage & facilitate practice management staff involvement • Provide administrative /frontline staff perspective/insight

Practices are welcome to include any other staff or patient representatives on their team.

Clinical Team Participation Expectations

For **Cohort I**, practices are expected to:

- Complete pre-work activities, including identifying QI team members, collection of baseline evaluation data, and completion of a baseline site self-assessment.
- Hold (at minimum) monthly meetings of their QI team.
- Participate in three in-person, half-day learning seminars (TBD central location).
- Participate in webinars and monthly conference calls
- Participate in in-person Learning Symposium at the completion of Cohort I.
- Collect and submit monthly EMR data.
- Provider National Provider Identifiers (NPI) of primary care and behavioral health providers in order to receive the claims-based analytic reporting of NH Accountable Care Project's Report Suite.
- Complete annual site self-assessment review.

Payer and Other Stakeholder Participants

Participation Expectations

For **Cohort I**, payers and other stakeholders are expected to:

- Complete pre-work questionnaire, including identifying team members.
- Participate in three in-person, half-day learning seminars (TBD central NH location).
- Participate in webinars and monthly conference calls and payment model discussions.
- Participate in in-person Learning Symposium at the completion of Cohort I.
- Complete annual evaluation questionnaire.

Who Should Join?

Types of Providers

- Health Care Systems with Primary Care Practices
- Independent Primary Care Practices
- Federally Qualified Health Centers and Other Primary Care Safety Net Providers
- Community Mental Health Centers

Types of Payers

- Commercial
- Commercial TPA
- Co-ops
- Medicaid MCO
- Behavioral Health
- Government Payers

Organizational Stage of Behavioral Health Integration

- Practices or health systems without integrated behavioral health that are committed to providing their patients with behavioral health services integrated into primary care.
- Practices or health systems with co-located (but not integrated) behavioral health services that are committed to providing their patients with fully integrated behavioral health services.
- Practices or health systems with integrated behavioral health in primary care that want to move to the next level of integration and develop sustainable models and financing.
- Community Mental Health Centers working to integrate primary care.

Interested?

To receive Application and Self-Assessment/Questionnaire materials, please email your Letter of Interest by October 31, 2015 to: Hwasun.Garin@UNH.edu.

Key Dates:

Oct. 31	Deadline:	Letter of Intent
Nov. 10	Deadline:	Completed Application Package including: Online Application, including Site Self-Assessment (for Practices) or Pre-work Questionnaire (for Payers and Other Stakeholders) Letter of Commitment, Team Member List, Non-Disclosure Agreement, Provider Identifiers (for Practices)
Nov. 17	Event:	Behavioral Health Integration Learning Collaborative Kick-Off 9:00 – 1:00 @ UNH School of Law, 2 White Street, Concord, NH

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2. Sharfstein SS. Integrated Care. *Am J Psychiatry*. 2011;168(11):1134-1135. doi:10.1176/appi.ajp.2011.11050766.
3. Kessler RC, Berglund P, Chiu WT, et al. The US National Comorbidity Survey Replication (NCS-R): design and field procedures. *Int J Methods Psychiatr Res*. 2004;13(2):69-92.
4. Gunn J William B., Blount A. Primary care mental health: A new frontier for psychology. *J Clin Psychol*. 2009;65(3):235-252.
5. Ansseau M, Dierick M, Buntinkx F, et al. High prevalence of mental disorders in primary care. *J Affect Disord*. 2004;78(1):49-55.