Agency for Healthcare Research and Quality

The Academy for Integrating Behavioral Health and Primary Care

Mission

The Academy serves as a national resource and coordinating center for those interested in integrating behavioral health into primary care. Integration in this context refers to primary care and behavioral health clinicians working together with patients and families, using a systematic and evidenced-based approach to provide patient-centered care. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Go to http://integrationacademy.ahrq.gov

Relevance

AHRQ seeks to build a centralized resource hub to provide the tools and materials to advance the field of integration, and to promote a collaborative environment for dialogue and discussion among leaders across behavioral health, and primary healthcare arenas. It is hoped that the Academy will unite this community by providing a forum; serving as a repository for materials professionals in the field want and need; identifying gaps in materials and generating solutions so further progress can be made; and drawing on expertise in the field to make integration efforts as efficient, relevant, and meaningful as possible.

Products

Information on seven aspects of integrating behavioral health and primary care: research, education, policy, financing and sustainability, clinical and community, health information technology, resources, and collaboration--including resources such as, for example:

- *The Lexicon for Behavioral Health and Primary Care Integration,* a set of concepts and definitions developed by expert consensus for what we mean by behavioral health and primary care integration.
- *Atlas of Integrated Behavioral Health Care Quality Measures*, a searchable atlas of literature on integration of behavioral health and primary care.
- *The Integrated Workforce Functions and Competencies Project,* an observational study of real-world practices that are effectively integrating behavioral health into primary care. The resulting competencies and other data can be used to refine the development of training programs and policy.

Audiences

Healthcare providers, researchers, policymakers, consumers

Settings of Care

Physicians' offices, clinics

Page last reviewed August 2013

Health Home Information Resource Center

The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (Section 2703/1945 of the Social Security Act), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. States will receive enhanced federal funding during the first eight quarters of implementation to support the roll out of this new integrated model of care. States with a substance use disorder-focused health home state plan amendment, approved after October 1, 2018, may request two additional quarters of enhanced funding, for a total of 10 fiscal year quarters.

Related Resources

- Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions
- Social Security Act Sec. 1945
- SAMHSA: Health Homes Resources
- State Medicare-Medicaid Data Guidance

The Health Home Information Resource Center was established by the Centers for Medicare & Medicaid Services (CMS) to help states develop these new models to coordinate the full range of medical, behavioral health, and long-term services and supports needed by Medicaid beneficiaries with chronic health needs. Recognizing that states are at various stages in developing health homes, the resource center offers a variety of technical assistance services as well as a resource library of continuously updated materials. States may use the resource center to request one-on-one technical assistance, access peer-learning opportunities, and find resources to guide their health home development and implementation. Technical assistance will include working with states on developing their draft health home proposals before submitting State Plan Amendments (SPAs) to CMS as well as ongoing support during the SPA development process.

Coordinating Care from Out-of-State Providers for Children with Medically-Complex

CMS.gov

Integrated Care Resource Center Available to All States

Resources Available to All States to Coordinate Care for High-Cost, High-Need Beneficiaries

A technical assistance resource center, the Integrated Care Resource Center (ICRC), is available to assist States in delivering coordinated health care services to people dually eligible for Medicare and Medicaid. ICRC offers a variety of technical assistance options to help states to develop integrated care programs that coordinate medical, behavioral health, long-term services and supports for dually eligible individuals. This resource provides technical assistance to States at all levels of readiness to better serve beneficiaries, improve quality and reduce costs. CMS has contracted with Mathematica Policy Research to lead ICRC.

Types of Assistance Available to States

Examples of the types of assistance provided by ICRC include:

- Providing one-on-one technical assistance to states in areas including program design, stakeholder engagement, data sharing and data analysis, contracting with health plans (including new plan requirements from the Bipartisan Budget Act of 2018 (P.L. No. 115-123), Financial Alignment Initiative or other state demonstrations, and health information technology;
- Creating customized state data profiles, using publicly available data, to help states interpret dually eligible beneficiary demographics, service utilization, spending, and other characteristics.
- Facilitating sharing of best practices across states;

Jun 17, 2022

Pathways for Specialty Care Coordination and Integration in Population-based Models

By: By: Sarah Fogler, PhD; Meghan O'Connell, MPH; Jacob Quinton, MD, MSHS; Chris Ritter, PhD; Brian Waldersen, MD, MPH; Purva Rawal, PhD

Innovation models

In support of the Centers for Medicare & Medicaid Services' (CMS) vision to advance health equity, expand coverage, and improve health outcomes, the CMS Innovation Center launched a strategic refresh in October 2021. This included setting a bold goal to have 100% of beneficiaries in Traditional Medicare and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030, where their providers are accountable for the quality and the total cost of their care. Beneficiaries will experience accountable care relationships mostly through advanced primary care or accountable care organizations (ACOs), and these entities are expected to coordinate with or fully integrate specialty care to deliver whole-person care. Achievement of this goal will make the health system more responsive and affordable for the people it serves.

While primary care remains central to a high-functioning health system, Medicare beneficiaries and their care providers are facing greater clinical and health system complexity. To complement population-based models, fully achieving whole-person care requires the additional depth and scope of services offered by specialty care and the effective coordination of primary and specialty care providers. Between 2000 and 2019, researchers have found that the portion of beneficiaries seeing five or more physicians annually increased from 18 to 30%, and the mean annual number of specialist visits increased by 20%. Moreover, they found that the average number of physicians with which a primary care provider needs to coordinate increased from 52 to 95 physicians from 2000 to 2019 —an 83% increase.[i]

In addition to the growing volume of visits, specialty care plays an outsized role in overall medical spending and offers important opportunities to increase the value of care. Between 2002 – 2016, Martin et al found that total annual health care spending increased by $806

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Sent: Wednesday, April 19, 2023 2:39 PM
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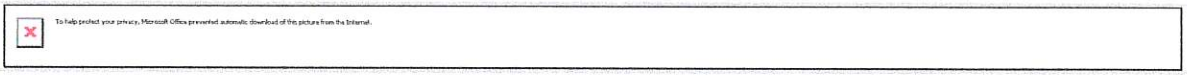

Behavioral Health Integration Technical Assistance (TA)

Volume 18, Issue 3

(April 19, 2023)

Earn CEs by participating in these expert, no-cost training and technical assistance events from the Bureau of Primary Health Care Behavioral Health Technical Assistance Initiative.

In This Week's Issue

NEW Communities of Practice Series Beginning Tuesday May 2 and Tuesday May 9

- Improving Postpartum Outcomes with Behavioral Health Integration (Begins May 9)
- Behavioral Health Integration Skills and Practices for Community Health Centers (Begins May 2)

Virtual Brown Bag Lunches

- Effective Referrals in Integrated Care- Presentation
- Effective Referrals in Integrated Care- Discussion

Integration of Oral Health and Behavioral Health Learning Collaborative

Contact Us

If you're interested in a topic and don't see it listed or need additional training and technical assistance, we want to hear from you! Send us an email to tell us about how we can better support you.

NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS • STRONG COMMUNITIES

<https://www.thenationalcouncil.org>

Resources

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

Featured Resources

Integrated Care Financing Series

View Resource