Promotion of Integration of Primary and Behavioral Health Care (PIPBHC) Grant Profile

7-1-19

Grant Info

- **Type of Grant:** Discretionary Grant
- **Area of Focus:** mental health treatment and recovery support
- **Purpose of Grant:** The purpose of this grant is to:
  - (1) promote full integration and collaboration in clinical practice between primary and behavioral healthcare
  - (2) support the improvement of integrated care models for primary care and behavioral health care to improve overall patient health
  - (3) promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental health, substance use disorders, chronic health conditions, and trauma.
- **Start and End Date of Grant:** 01/01/2019-12/31/2023
- **Amount of Award (all years):**
  - **Federal Award Amount:** $10,000,000.00
  - **State Award Amount:** $0
- **% Match Required: 0%**

Grant Info

- **Source of Funding:**
  - Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS)
- **BHDDH Project Director and Email Address:**
  - Erin McCollum, Erin.McCollum@bhddh.ri.gov
- **Subrecipient Agency/Agencies:**
  - Gateway Healthcare
  - Community Care Alliance (CCA)
- **Subrecipient Agency Contacts and Email Addresses:**
  - Gateway: Kathleen Chase; KChase1@Lifespan.org
  - CCA: Daniel Barbosa; DBarbosa@CommmunityCareRI.org
- **Evaluation Contact and Email:**
  - Jennifer Van Dine
  - Jennifer.VanDine@bhddh.ri.gov

Overview

- RI PIPBHC will target 1000 children and their families, or adult members of families with children, who are currently experiencing or at risk for substance use disorder and/or co-morbid physical and mental health conditions. The model will follow a family-based treatment approach, aiming to prevent child maltreatment by addressing high-need, underserved, and vulnerable populations with wrap-around services and coordinated physical and behavioral healthcare. All members of a qualified family or household will be eligible for PIPBHC-funded services along the spectrum through prevention, treatment, and recovery.

- The initiative will focus on two high-need communities designated as medically underserved by the Health Resources and Services Administration (HRSA): Washington County and Blackstone Valley (Woonsocket and surrounding areas). The program's goal is to identify, screen, and assess youth and their families in a primary care setting through an embedded behavioral health clinician.

Overview: Goals and Objectives

- By the end of the project, 100% of the centers participating in the project will have created policies that operationalize integrated care.
- By the end of year one 100% of the centers participating will have co-located services.
- By the end of the grant 80% of the center will share resources with the behavioral health/health center.
- By the end of year 1, Evidence Based Practice will be identified by each community.
- At least one center will implement tele-health by the end of year 2.
- By the end of year one, all site staff will be trained in co-occurring physical and behavioral health conditions.
- By the end of year 2 100% of the centers will be using coordinated treatment plans.
- By the end of year one, all centers will use common screening tools for behavioral health and health conditions.
- By the end of year one, all centers will use a common trauma screening.
- By the end of year one all behavioral health centers involved in this project will offer smoking cessation programs.
- By the end of year two, all health centers will offer peer recovery services.

Required Activities

- Develop a plan to achieve fully collaborative agreements to provide services to special populations.
- Develop a document that summarizes the policies, if any, that serve as barriers to the provision of integrated care, and the specific steps, if applicable, that will be taken to address such barriers.
- Describe the partnerships or other arrangements with local health care providers (e.g., community behavioral health centers, health centers, school-based health centers, substance use treatment facilities) that will provide services to the selected special populations.
- Develop an agreement and plan to report to the Secretary of Health and Human Services (to be referred to as “the Secretary”) performance measures data necessary to evaluate outcomes and facilitate evaluations across participating projects.
- Develop a plan for sustainability beyond the grant or cooperative agreement period. One of the important goals of this cooperative agreement is to develop and implement the policy and financing policy changes required to sustain project activities when the grant ends.

Required Activities (Cont'd)

- Develop a continuous quality improvement (CQI) plan and oversight process. Grantees are required to engage with a coordination team or advisory council (that may already exist at the State level) among mental health, substance use, primary care, and children's services). This coordination team or advisory council should also include family, youth, peers, and consumer organizations.
- Provide outreach and other engagement and retention strategies to increase participation in, and access to primary care and behavioral health treatment and prevention services for diverse populations.
- Provide direct primary care and behavioral health treatment (including screening, assessment, and care management) and prevention services for diverse special populations at risk.
- Screen and assess clients for the presence of co-occurring chronic physical conditions; mental and substance use disorders for adults with serious mental illness; mental illness; children and adolescents with serious emotional disturbance; and individuals with a substance use disorder.

Required Activities (Cont'd)

- Identify the evidence-based or promising practices integrated care model(s) for primary care and behavioral health.
- Develop a plan for the implementation of services for the identified special population. The plan must include descriptions of the integrated services that will be provided, the roles of the integrated care team and how they relate to the service provision, and the expected impact on the physical and behavioral health outcomes of the individuals served by the grant.
- Achieve Modified Stage 2 Program Requirements for Providers and Hospitals, as defined by the Centers for Medicare and Medicaid Services (CMS), by the end of the grant.
- Provide all of the following components of person-centered, integrated care services:
    - Care coordination including comprehensive care management and comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
    - Shared decision-making
    - Health promotion
    - Individual and family support
    - Referral to community and social support services, including appropriate follow-up

Required Activities (Cont'd)

- Implement tobacco cessation, nutrition/exercise interventions, recovery and prevention of substance use disorders, in addition to other health and behavioral health promotion programs (e.g., wellness consultation, health education and literacy, independent living skills, sleep hygiene, prevention and recovery, and illness, stress, anger and self-management programs, etc.) for the special populations.

Approach

- Sub-recipient agencies will provide on-site behavioral health clinicians for Federally Qualified Health Centers (FQHC) and other sites selected by the agency.
- Formal eligibility criteria:
  - Receiving primary care services at a participating FQHC
  - Presence of:
    - Child or adolescent under 18 in the household, *or*
    - Current pregnancy
  - Any member of the household, child or adult, has a present diagnosis, history of, or indications on screening that they are at risk for the following:
    - Substance use disorder diagnosis, including alcohol, tobacco, opioids, and others, *or*
    - Mental health/SED diagnosis *and* chronic disease diagnosis, *or*
    - Mental health/SED diagnosis *and* a complex medical condition diagnosis

Approach (Cont'd)

- The sub-recipient agencies will partner with local providers to implement and promote evidence-based programs, such as:
  - smoking cessation, health literacy, wellness consultations, and behavioral health promotion (including stress, anger and self-management, sleep hygiene, and nutrition and exercise programs).
  - These programs will be developed using the research finding from the SAMHSA Integrated Health Center to ensure programs are impactful; for example, programs will be 6 months or longer and include education combined with guided activity, and nutrition programs combined with exercise classes.

- The sub-recipient agencies will partner with established Health Equity Zones (HEZ) to ensure existing resources are being leveraged.
  - The HEZ initiatives have prior completed needs assessments; therefore, plans will be developed for existing community-recognized health and behavioral health care issues that were identified.

Approach (Cont'd)

- A Local Advisory Committee (LAC) of stakeholders and community partners will convene with the goal of establishing the community as the "locus of responsibility" for meeting the needs of the target population.
- Additionally, it is appropriate to use PIPBHC Integrated Family Health Home Team for other workforce development opportunities, such as recruiting and retaining diverse and qualified staff using established positions or paid internships, thereby providing supervised clinical hours in a community-based setting; cross-training of staff roles and qualifications; and tuition reimbursement for the purposes of recruitment of said staff.
- As a core requirement of this grant, the engaged Community Mental Health Center (CMHC) and FQHCs will maintain a unified Integrated Treatment Plan, shared between both agencies.
- PIPBHC has a public health epidemiologist employed at BHDDH who will be responsible for data and evaluation.
- Individuals receiving treatment and recovery services will be administered a survey at baseline, at 6 months post baseline and at discharge. The survey tracks outcomes in areas including but not limited to: overall health, psychiatric symptoms, stability in housing, substance use, employment/income/education, criminal justice status and social connectedness