Report: Meeting Three

Colorado State Innovation Model (SIM) Project

Health Care Provider Workgroup

AUGUST 15, 2013

At this third and final meeting of the SIM provider stakeholder group, 21 participants representing behavioral and physical health providers, state government, practice transition specialists and academic institutions focused on three main topics.

- Policy and regulatory barriers to integrating care.
- Establishing a workforce baseline and modeling future needs for primary and behavioral health care providers.
- Evaluating options for investing innovation grant funding.

This group of experts agreed on several recommendations and reached consensus on methods for assessing workforce needs through an integrated care framework. Participants also discussed drivers of innovation that may be targets for future funding.

These are the group's recommendations, grouped into subject categories.

SIM Vision and Goal

Recommendation 1: *Ask the SIM Public Health Stakeholder group to consider refining public health statement in the vision. The group provided a recommendation for the language change:*

Current language: ***Leveraging*** the power of our public health system to support the delivery of clinical care and achieve broad population health goals.

Dayna Matthew, a faculty member at the Colorado School of Public Health and the University of Colorado Law School, updated her efforts to identify the policy and regulatory barriers to integrated care. As part of the SIM project, Professor Matthew is conducting legal research into the opportunities and barriers to implementing best practices. She has conducted key informant interviews with SIM stakeholders and she is researching policies in other states.

Professor Matthew noted that a review of successful SIM grants showed that each includes a section on the legislative and regulatory changes needed to support the innovation goal. She proposes adding a section in Colorado's state innovation plan that discusses how to help lawmakers understand the policy changes that could improve health.

While the current delivery of behavioral health and primary care faces legal obstacles, the group was reminded that, as a starting point, we are working specifically on policy and legal challenges that relate directly to integrating behavioral health in primary care settings for the vast majority of the population. It was acknowledged that a small subset of the population will continue to use their mental health provider/facility as a primary care home.

Professor Matthew recommended seven areas of focus:

1. **Payment models that will support integration.**

   A system-wide need to change payment models would include these changes, in particular: shifting from the per member per month reimbursement

model for federally qualified health centers (FQHCs); and for all practices, removing the diagnosis basis from billing regulations; reimbursing for a consultative model; focusing on outcomes rather than visits; and reframing rules regarding which providers can bill for which services.

2. **Colorado's model of regulating behavioral health.**

   Three different agencies regulate behavioral health in the state. As necessary, propose streamlining the governance structure and ensure that it supports integrated care.

3. **State rules governing behavioral and physical health.**

   Colorado has more than eight volumes of rules, leading to contradictions and complexity. Aligning and clarifying the rules will be important.

4. **Health Insurance Portability and Accountability Act (HIPAA) privacy rules.**

   The health care field and policymakers need easily understandable and accessible guidance on who can disclose what information to whom, when and how.

5. **Alignment.**

   There is a need to align licensing, release of information, and service delivery plans between behavioral health and primary care

6. **Building and construction regulations.**

   These regulations must be consistent for substance abuse, behavioral health and primary care.

7. **Liability and professional insurance.**

   Review and assess to what extent liability and professional insurance are barriers to integrated care. This could include variations in liability based on whether a practice directly hires a behavioral health provider rather than contracting for a provider.

The group acknowledged that some federal regulations are equally high, or even higher, barriers to care integration. For instance, group members cited federal regulations (42 CFR Part 2) that govern confidentiality in the substance abuse field. The general consensus is that such issues may reach beyond the innovation plan but they should be flagged.

Policy and Regulatory Barriers

Recommendation 2: *Provide additional detail that supports the "scopes of integration" as outlined in the Colorado Framework outlined by the University of Colorado School of Medicine's Department of Family Medicine, describing the types of functions and clinical services expected from practices within each scope of integrated care capacity.*

Recommendation 3: *Describe the similarities and differences between the Colorado Framework scopes of integration and the six Substance Abuse and Mental Health Services Administration (SAMSHA) levels that many Colorado organizations use.*

The group spent its entire session on July 12 discussing the proposed Colorado Framework of integration developed by the University of Colorado School of Medicine's Department of Family Medicine, which is based on the Agency for Healthcare Research and Quality's Integrated Care Lexicon. This framework lays out components that each integrated care practice must develop and sustain, including shared patients and mission, integrated care teams and supporting infrastructure. The framework has three levels of practice capacity for identifying and responding to patients, from those with less acute physical and behavioral health needs to those with complex co-morbidity issues.

The group realized that many behavioral health groups in Colorado are addressing integration based on the SAMSHA six-level model. The SIM project should clarify the similarities and differences between the Colorado Framework and the SAMSHA model to create a better foundation for ongoing discussion and implementation.

The group reaffirmed earlier discussions that Colorado's SIM plan should aim to get primary care practices to at least reach Scope One of the Colorado Framework integrated care plan and then support infrastructure and workforce needs to help practices move to Scope Two and Scope Three, if that makes sense for that practice.

Levels of Integration

Recommendation 4: *Focus the workforce needs assessment on reaching 80 percent of the population (Colorado's SIM goal), including a concentration on the*

Interstate 25 corridor between Fort Collins and Colorado Springs. But develop strategies that acknowledge and address concerns and needs in less populated areas of the state.

The primary care workforce in Colorado is often described as inadequate to provide access and comprehensive care to the population. The group discussed its understanding of Colorado's primary care workforce and whether there are gaps in what we know or what we need to know as we move forward.

Colorado has a fairly robust primary care workforce, but it is not evenly distributed across the state. Many regions suffer from a chronically low staffing level. In addition, fewer physicians in Colorado are selecting primary care. For the past several years, Colorado has attracted more physicians, but a smaller percentage of them are practicing in primary care. Colorado is continually assessing workforce concerns and developing projects to support the provider pipeline. One report documented 56 workforce initiatives in Colorado as of a few years ago. In addition, Colorado is benefiting from more nurse practitioners (NPs) and physician assistants (PAs). A greater percentage of these practitioners go into primary care settings compared to physicians.

The participants discussed the need to ensure that the primary care workforce is working at its highest level of licensure and that Colorado is building teams of primary care professionals in order to increase access and comprehensive care.

More data on the primary care workforce may become available when the Colorado Department of Regulatory Agencies (DORA) begins to receive data under House Bill 12-1052, a mechanism for collecting provider information on an ongoing basis and at the time of professional license acquisition and renewal. However, much of the new data elements are optional responses for providers.

Participants noted that when practitioners are trained in rural areas and areas with workforce shortages, they are more inclined to stay and practice there, suggesting that perhaps Colorado can do even more to recruit locally and train staff locally. . Several participants suggested expanding rural training rotations and rotations in an integrated behavioral and primary care setting as well as continuing to expand tele-health and regional hubs in low primary care capacity areas.

Primary Care Workforce – Baseline and Future Needs

Recommendation 5: *Assess the behavioral health workforce to better understand its major functions and existing capacity.*

Recommendation 6: *Define functions for the integrated care framework and types of providers that can provide the skills necessary to meet those functions.*

Recommendation 7: *Model the estimated behavioral health workforce based on provider ratios, behavioral health panel sizes or both.*

The integration of behavioral health and primary care depends on an adequate behavioral health workforce. But the definition of an adequate behavioral health workforce is not well defined. This discussion acknowledged many gaps in our understanding of both the state's baseline behavioral health workforce and the future needs associated with implementing Colorado's SIM goal as well as the integrated care framework.

Participants agreed that there is less publicly available data about the behavioral health workforce than there is about the primary care workforce. Several studies and task forces over the years have included recommendations, yet little is known about whether the recommendations were implemented. State databases provide limited information and the federal designation for a mental health professional shortage area looks only at psychiatrists rather than taking a broad look at the behavioral health workforce. Data is limited on the numbers of patients seen by behavioral health providers, the kinds of patients seen by different types of behavioral health providers and the places they practice. Finally, little is known about how this workforce breaks down around adult care versus pediatric care.

The group acknowledged that future workforce needs are a moving target. Changes in insurance coverage and health care delivery and payment already underway may alter how the workforce is structured and how incentives are provided, but we don't know exactly what that will look like.

Group members agreed, however, that despite uncertainty, it important to assess and plan for the future. Behavioral health workforce needs that can be addressed now include:

1. Mapping the range of skills of the behavioral health workforce to the types of functions necessary to provider behavioral health in a primary care setting. This assessment would lead to a better understanding of the types of providers that will be critical to the effort and would tart discussions about training and recruitment.

2. Establishing a psychiatrist consultation network for primary care doctors as well as a reimbursement protocol for advising on medications and acute needs.

3. Investigating ways to leverage the existing workforce to build behavioral health capacity. Participants had some ideas, including requirements for certified addiction counselor certification and mental health first aid for existing mid-level primary care providers and offering NPs and other qualified staff the opportunity to add behavioral health training to their skill sets. The group raised the issue of whether it would be better for primary care practices to have a licensed behavioral health provider in order to place a mental health "hold" on a patient if needed.

4. Worrying less about "letters behind the name" and more about the training and experience of the behavioral health staff to function in a primary care setting and work with patients to change their health behaviors. A few participants said that psychiatric nurses and licensed Master of Social Work (MSWs) could be important providers for this framework.

Group members discussed mapping the mental health resources in areas near primary care practices and making connections so that the primary care providers feel supported and have established relationships when a patient's behavioral health care needs are beyond the practice's capacity.

The group was asked to think about methodologies for modeling behavioral health workforce needs. All agreed that modeling is difficult and there is no truly correct way to approach it. The facilitators asked for feedback on two options. The first is to use a ratio of behavioral health providers to primary care providers such as 1:4 (a model used by the federal Department of Veterans Affairs and Aspen Pointe in Colorado). The second would estimate need based on panel sizes. For example, one model could be based on one behavioral health provider responsible for between 3,600 and 5,000 patients in a clinic. The participants did not recommend a specific panel size.

The researchers would look for common assumptions in Colorado or in published literature.

We reached general agreement that estimation using panel sizes is a fair approach, with the caveats that panels are different for each clinic and some practices may not have a big enough panel to justify bringing in full-time behavioral health staff. It is important to think through alternative staffing options based on the size of the practice.

Summary

Wrapping up work, the group reached consensus on several recommendations for the SIM plan developers to take forward:

- Panel size is an option for estimating behavioral health provider needs, as is provider ratios. They are likely the best available options.
- Concern that behavioral health providers in primary care be licensed.
- Substance abuse treatment is important but could be an added skill for the existing workforce.
- The behavioral health needs for any one practice are impossible to estimate for the SIM plan. Once implementation starts, practices will need to assess and re-assess over time based on changing population needs.
- The medical and behavioral health needs of children differ from adults. Implementing integrated care should pay specific attention to children.

The group also revisited the question of where best to invest any funding that might become available to support implementation of the framework. These ideas emerged:

- Team training and culture transformation coaches.
- Developing systems for behavioral health consultation and expert extension to rural areas.
- External assistance to practices to help them assess behavioral health needs based on practice data and to determine the behavioral health capacity they should add.
- Evaluation design and implementation in order to assess whether behavioral health integration increases efficiency, produces better health outcomes and lowers costs. Evaluation should be an ongoing process.

Appendix A: Participation List

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

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

Mindy Klowden, *Jefferson Center for Mental Health*

Debbie Costin, *Colorado Association of School Based Health Centers*

Katherine Blair, *Governor's Office*

Chet Seward, *Colorado Medical Society*

Shelly Spalding, *Behavioral Healthcare Inc.*

Julie Holtz, *Colorado Access*

Jeff Thormodsgaard, *Colorado Association of Family Practitioners*

Terri Hurst, *Colorado Behavioral Healthcare Council*

Moe Keller, *Mental Health America of Colorado*

Jen DeGroff, *AspenPointe*

Sabrina Bayliss, *AspenPointe*

Polly Anderson, *Colorado Community Health Network*

Stephanie Kirchner, *University of Colorado Department of Family Medicine*

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

Carissa Kinman, *Office of Integrated Healthcare Research and Policy, CU Denver School of Medicine, Department of Family Medicine*

Anna Vigran, *Colorado Health Institute*

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