**Integrated Behavioral Health Committee Charter**

**Charge:** The Integrated Behavioral Health Committee is charged with supporting the development of, and ongoing learning around, sustainable approaches to integrated behavioral health into a wide variety of primary care practices. The IBH committee will act as content experts for informing the implementation of the CTC IBH pilot project and work in partnership with the health plans in program oversight and evaluation and in reporting to the CTC Board of Directors. The committee will also act as an advisory group to inform PCMH kids as they develop training programs to meet the needs of pediatric/adolescent/families.

The committee will consider the variable needs of the practices and patient populations and provide recommendations that will support the different types of practices in CTC (e.g. pediatric, family, and internal medicine, solo practitioners, group practices, federally qualified health centers, and hospital-based clinics). The recommendations will consider: developmental contract requirements for clinical models adaptable to the variety of practice types in CTC; payment models to be included in the developmental contract, metrics for success, and recommendations for training in integrated behavioral health.

As appropriate, The Committee will formulate recommendations for the State Innovation Model (SIM) and CMHC for improving population health through the provision of behavioral health interventions within primary care.

Efforts of the Integrated Behavioral Health Committee will be geared towards:

* Understanding the differences between adult and pediatric behavioral health care, including the focus on diagnosis in the former versus prevention in the later.
	+ Eliminating disparities in health care outcomes for people with co-occurring conditions with an anticipated emphasis on medical conditions which are amenable to behavioral health interventions and modifiable health related behaviors (such as diabetes, COPD, CHF, asthma, attention deficit condition, and developmental delay)
	+ Managing and improving behavioral health conditions (such as depression, anxiety, ADHD, and addiction disorders) and health-related behaviors (such as healthy eating and tobacco cessation)
	+ Broadening the screening and intervention plans for behavioral health conditions within primary care practices
* Promoting a multi-generational approach that recognizes the patient within the context of a family, school, and/or community unit
* Strengthening patient/family engagement and assisting patients/families with learning and utilizing self-care management strategies
* Improving communication and coordination between primary care and mental health and addiction disorder providers
* Leveraging existing resources and building on existing assets, competencies and capacities within the health care delivery system and health plans
* Improving access for behavioral health services across all age groups
* Incorporating the Joint Principles for Integrating Behavioral Health into the Patient Centered Medical Home into recommendations made to Board
* To disseminate best practices and design of models of care supporting the triple aim including the integration of behavioral health and transformation of design work based on population needs

**Duties, Functions and Responsibilities**

* The Integrated Behavioral Health Committee functions as a CTC Committee that brings together primary care and behavioral health experts and reports to Board
* Develop work plan and determine deliverables and timeline
* Conduct CTC site assessment to determine behavioral health needs including clinical, payment and training needs
* Make recommendations to Board on clinical and payment reform models to integrate behavioral health in CTC
* Recommend process and outcome measures for successful integration of behavioral health to Data and Evaluation Committee
* Recommend competencies for clinical staff and support training through Practice Transformation, Provider Best Practice and Nurse Care Manager Best Practice Committees
* Recommend training in integrated behavioral health to Practice Transformation Committee
* Contribute to statewide efforts to improve integrated behavioral health workforce and infrastructure

**Membership**

* Co-Chairs (March 2016)
	+ Provider Representative: Matt Roman, Thundermist Health Center
	+ Health plan representative: Tracey Cohen, MD, Neighborhood Health Plan of Rhode Island
* Staff support : Deb Hurwitz, Pano Yeracaris, Susanne Campbell, Hannah Hakim and Michele Brown
* Members: Membership is open to all CTC practices, participating health plans and additional members or agents of the RI PCMH community; as such additional members may be identified and invited from time to time by the Committee. Members are self-nominating, and shall include medical and behavioral health providers, referral/care coordination staff, state agencies, etc who can speak to the resources and processes within their respective organizations

**Work Processes**

* Meets at least 8 times/year on the third Thursday from 7:30-9am
* Structured agenda
* Reports committee work to the designated committee
* Collaborates with the Community Health Team pilot program
* Collaborates with PCMH Kids and integrates key components into the overall IBH recommendations
* Collaborates with Practice Transformation, Provider Best Practice, and Care Manager Best Practice Committees

**Attachment A: Background and Definitions**

**Problem Statement**

Nearly half of U.S. adults will develop at least one mental health condition in their lifetime. People with mental illness die earlier than the general public and have more co-occurring mental health conditions:

* 68% of adults with a mental illness have one or more chronic physical conditions
* 1 in 5 adults with mental illness have a co-occurring substance disorder
* Rhode Island’s rate of illicit drug use among youth was higher than the national rate in 2011-2012 (15.2% compared to 9.8%)
* Rhode Island’s rate of alcohol dependence or abuse among persons aged 12 or older was higher than the national rate in 2011-2012 (8.9% compared to 6.6%)
* Rhode Island’s rate of heavy alcohol use among persons aged 21 or older was higher than the national rate (8.9% compared to 6.9%)

**Need for Evidence-Based Behavioral Health Treatment Models within Primary Care**

Patients seen in primary care have a high prevalence of behavioral health conditions:

* Major depression-10%
* Panic disorder-6%
* Other anxiety disorders-7%
* Substance abuse disorders-14%
* Any mental health disorder-28%
* Smoking-20%
* Obesity-30%
* Sedentary lifestyle-50%
* Non-adherence-20-50%

There is evidence that supports why behavioral health should be a core service of patient-centered medical homes: at least 50% of patients will experience better access to mental health if offered in primary care. The vast majority of people will not accept a referral to specialty mental health offered by a primary care provider. Racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Studies indicate that minorities turn more often to primary care for treatment of behavioral health needs. Of concern is that integrated primary care does not flourish in fee for service environments because billing and documentation requirements of two systems (mental health and medical) are too different to work easily together as one service. In considering financially sustainable models, there is evidence of effectiveness and cost savings coming from sites that have some form of capitated or bundled payment for total care, not just mental health care.

**Definitions**

* Behavioral Health Care: an umbrella term and refers to a continuum of services including mental health care, unhealthy substance use diagnosis and treatment and support to address unhealthy lifestyles that influence chronic conditions and quality of life (UMMS PCMH Behavioral Health Toolkit).
* Coordinated Care: behavioral health and medical care provided in different settings but with more seamless interface between the settings.
* Co-located Care: behavioral health and medical care delivered separately, but within the same location, sharing staff and facilities.
* Integrated Care: behavioral health and medical care share one treatment plan with behavioral and medical elements.

**Attachment B: Joint Principles for Integrating Behavioral Health into the PCMH**

Joint Principles for Integrating Behavioral Health into the Patient Centered Medical Home, *Annals of Family Medicine, 2014*:

1. Physician Directed Medical Practice: The physician’s practice will generally be the physical location of the PCMH and this practice will rely on the team of health care professionals who will act together to integrate the physical, mental, emotional and social aspects of the patient’s care needs. This may be by making use of connected behavioral health specialists in the medical home neighborhood.
2. Whole Person Orientation: A whole person orientation has to be imagined as behavioral together with the physical.
3. Care Coordination: Care is coordinated or integrated across all elements of the complex health care system and mechanisms include: shared registries, shared medical records 9especially shared problem and medication lists), shared decision making, shared revenue streams and shared responsibility for the patient care plan.
4. Quality and Safety: Partnerships include the physician, the patient, and behavioral health clinician. Medical records (with appropriate security, privacy and confidentiality protections) must incorporate behavioral health notes, mental health screening, case finding tools and tracking of behavioral health outcomes.
5. Enhanced Access:Access for patient, family and physician is to include behavioral health resources through systems of collaboration, shared problem solving, flexible team leadership and enhanced communication.



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