SAMHSA - PIPBHC Summary

Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Cooperative Agreements

https://www.samhsa.gov/grants/grant-announcements/sm-17-008

Agency: SAMHSA

Authority: 21st Century Cures Act (section 9003) and Public Health Service Act (section 520K)

Total Awards: up to 11 awards for a total of $110M over five years

Per Award Amount: up to $2M per year for up to five years per award (9/30/17 to 9/29/2022)

Due: May 17, 2017

Eligibility: State agency with one or more “qualified community programs” or “community health centers” (with at least two years of experience providing relevant services) that serve an area or population(s) of high need. (SAMHSA will not fund proposal that duplicate any other related HHS initiative.)

- **Qualified community programs include:** community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs (per section 1913(b)(1) of the Public Health Service Act)
- **Community health centers include:** community health centers (FQHCs but not including look-alike health centers), health care for the homeless, public housing health centers, and migratory and seasonal agricultural workers health centers (per section 330 of the Public Health Service Act)

The purpose of this cooperative agreement is to:

- promote full integration (or bi-directional) and collaboration in clinical practice between primary and behavioral healthcare;
- support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); and
- promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.

SAMHSA expects that a continuum of prevention, treatment, and recovery support services will be offered to consumers within the program. The full spectrum of behavioral health services is encouraged.

These activities will be provided to one or more of the following **special populations**, and applicants must indicate which one or more of the four populations will receive integrated care services:

- Adults with a mental illness who have co-occurring physical health conditions or chronic diseases
- Adults with a serious mental illness who have co-occurring physical health conditions or chronic diseases
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- Children and adolescents with a serious emotional disturbance with co-occurring physical health conditions or chronic diseases
- Individuals with a substance use disorder

**State grantees** are required to:

- Develop a plan to achieve fully collaborative agreements to provide services to special populations
- Develop a document that summarizes the policies that serve as barriers to the provision of integrated care, and the steps that will be taken to address such barriers
- Describe the partnerships or other arrangements with local health care providers that will provide services to the selected special populations
- Develop an agreement and plan to report to the Secretary of HHS performance measures data to evaluate outcomes and facilitate evaluations across participating projects
- Develop a plan for sustainability beyond the cooperative agreement period
- Develop a continuous quality improvement plan and oversight process (Grantees are required to engage with a coordination team or advisory council, which may already exist at the State level, among mental health, substance use, primary care, and children’s services)

**Provider Organizations**

Selected “qualified health programs” are required to partner with a “community health center” to provide integrated primary care services. And selected “community health centers” are required to partner with a “qualified health program” to provide integrated behavioral health services.

Provider organizations are required to be located in communities of high need (federally recognized tribes, an Urban Indian organization, tribal organizations, tribally operated clinics, urban health clinics, or a HRSA designated health professional shortage area). It is encouraged that provider organizations be located in geographically diverse regions of the state to increase equitable access to treatment and recovery support services for the population(s) of focus.

It is recommended to partner with non-profit, faith-based, adolescent and/or transitional aged youth, substance use treatment provider agencies, FQHCs, school-based health centers, primary health care, education, or other agencies serving the population of focus.

Selected provider organizations are required to:

- Provide outreach and other engagement and retention strategies to increase participation in, and access to primary care and behavioral health treatment and prevention services
- 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
- Include routine health screening for cholesterol and blood lead, hypertension, tobacco, communicable disease, and cancer for adults 18 years of age and older. Similarly, health screening for children and adolescents must include a growth chart with BMI, age-appropriate
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- Immunizations for communicable disease, age-appropriate physical examinations, blood pressure, tobacco use, oral health, and scheduled age-appropriate wellness visits as recommended by CDC and the AAP.
- Identify those consumers most in need of integrated services (including those with HIV/AIDS and Hepatitis A, B, and C, as well as those with histories of trauma)
- Identify the evidence-based integrated care model(s) for primary care and behavioral health
- Develop a plan for the implementation of services for the identified special population
- Provide 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; and referral to community and social support services (including appropriate follow-up).
- Implement tobacco cessation, nutrition/exercise interventions, recovery and prevention of substance use disorders, in addition to other health and behavioral health promotion programs
- Use evidence-based practices for tobacco cessation, nutrition/exercise, chronic disease self-management, and appropriate mental health and substance use interventions, as well as assessment and treatment of behavioral health and physical health conditions
- Achieve Modified Stage 2 Program Requirements for Providers and Hospitals, as defined by CMS, by the end of the grant (organizations must develop and demonstrate the ability to meet the Modified Stage 2 Objectives and Measures for 2017 post award of the grant, and providers should have an EHR that meets Meaningful Use Stage 2)

Measurement

Grantees will be required to report performance measures in the following categories (please see the Funding Opportunity Announcement for the specific measures):

- GPRA Consumer National Outcome Measures (NOMs)
- PIPBHC Specific Health Outcomes
- Infrastructure, Prevention and Promotion (IPP) performance measures

Grantees are required to maintain an 80% follow-up rate on PIPBHC outcomes at six-month intervals post baseline and at discharge.

Budget Restrictions

- No more than 10% of the total award can be allocated for administrative costs at the state level
- The remaining 90% must be allocated to “qualified community programs” or “community health centers” to provide direct integrated care. Of the 90%, no more than 10% may be allocated for evaluation and data collection, and no more than 15% may be used for infrastructure development (e.g., developing partnerships with other service providers, adopting and/or enhancing HIT systems to document and manage client needs and outcomes; training/workforce development; redesigning processes between primary care and behavioral health provider settings; facility modifications and HIT needed to support bidirectional integration services; and policy development to support needed service system improvements)