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CONFERENCE ABSTRACT

Building integrated teams to address mental and behavioral health needs in rural primary care: The Western Colorado COEARTH project

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Michael Olson[1], Angela Ammon[2], Christine Page[3], Lilia Larkin[3]

1: SCL Health - St. Mary's Hospital, United States of America;
2: Valley View Hospital, Family Medicine, Eagle, Colorado, United States of America;
3: Valley View Hospital, Women's Health, Glenwood Springs, Colorado, United States of America

Introduction: Primary care in the U.S. is often called the "de facto mental health system." Researchers estimate that anywhere from 40-60% of patient complaints in primary care have no organic or medical origin (Kessler et al., 2005).

Description of practice change: A practice transformation program to coordinate and integrate team-based mental/behavioral health in rural primary care was developed (i.e., COEARTH: Colorado is expanding rural team-based healthcare). Potential practices completed initial assessments and were stratified into "coordinated", "co-located", or "integrated" tracks. Participants completed monthly visits, onsite-training, coordination with residency faculty (St. Mary's) and our RMHP (Rocky Mountain Health Plans) partners, an annual learning collaborative, and exposure to family physician residents with experience in team-based integrated behavioral/mental health care.

Aim/theory of change: Assist rural primary care teams to transform person-centered care (developing new models/teams for coordinated, co-located, or integrated care) via QI team engagement, and partnering with our residency program at St. Mary's and RMHP QI team. Theory of change based on motivation science and motivational interviewing constructs.

Targeted population and stakeholders: Our program targeted small primary care practices (<6 providers) in rural, underserved communities. Key stakeholders included rural populations at risk, physicians and other healthcare providers/networks, residency training programs, RMHP, and the Caring for Colorado Foundation.

Timeline: The project began in August, 2015 and concluded in August of 2018. Highlights: Ours was the first partnership of its kind in our region, bringing a family medicine residency together with a health insurance team to focus on mental/behavioral health risk in rural primary care. The project has penetrated the rural Western Slope of Colorado serving hundreds of thousands of patients. Our finish rate has been >98% with clinics completing varying levels of the program, many hiring full-time mental health providers as team-members. We have worked in concert with the State Innovation Model (SIM) team in Colorado, a 65 million dollar CMMI grant/project to improve integrated care in the state and develop new payment models for team-based care.

Comments on sustainability: Integrated care services and training have always struggled for sustainability in a fee-for-service world. Even in the most highly efficient systems, patient fees and insurance billing only cover a fraction of the costs. Fortunately, through SIM, PCMH, and ACO

models, Colorado's healthcare landscape is changing to be much more supportive of global funding strategies.

Comments on transferability: All materials developed during this program are publically available. Practices in this project made progress toward better coordination and integration following the curriculum/QI team process we developed without financial support.

Conclusions/Discussion: Rural practices completed varying levels of the program, thereby enhancing care to vulnerable/at-risk rural populations. Our family physicians, trained in integrated care, have completed electives and rotations in rural practices and many graduates have chosen to practice in these communities.

Lessons learned: There is interest from multiple stakeholders around creating better models/teams to provide integrated mental health/behavioral health care in rural communities. Provider champions in QI process/teams is critical. Patient engagement in rural settings around enhanced teams requires cultural awareness, competency, and sensitivity.

Keywords: integrated mental/behavioral health; rural at risk populations; primary care leadership in care integration; integrated care and its dimensions