

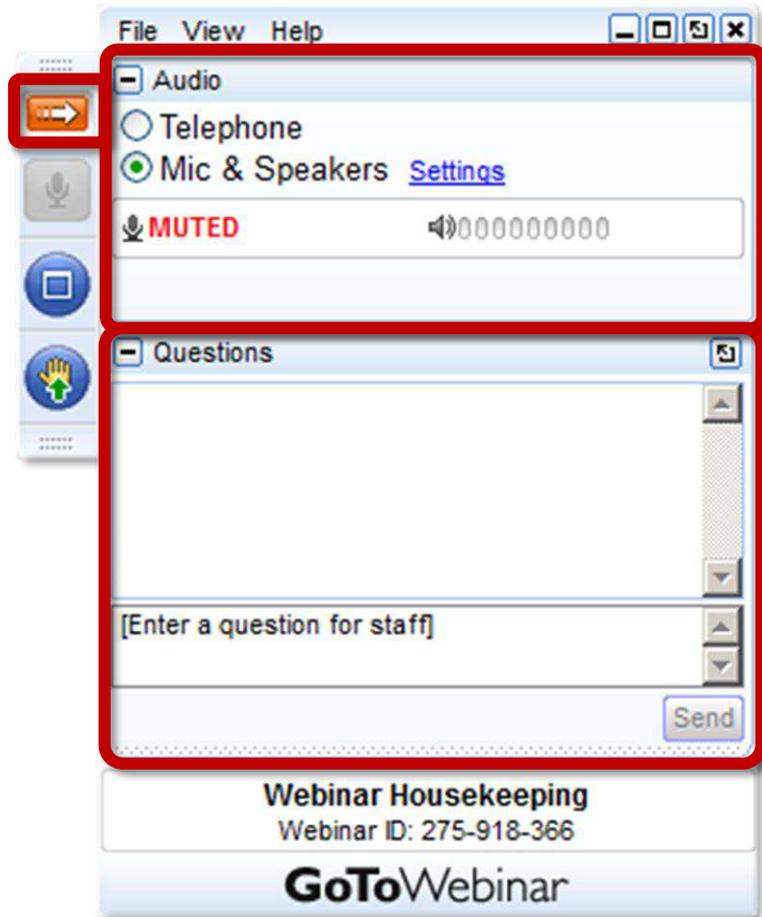
An introduction to Behavioral & Primary Care Integration

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May 27, 2016



Quick Reminders



Your Participation

Open and hide your control panel

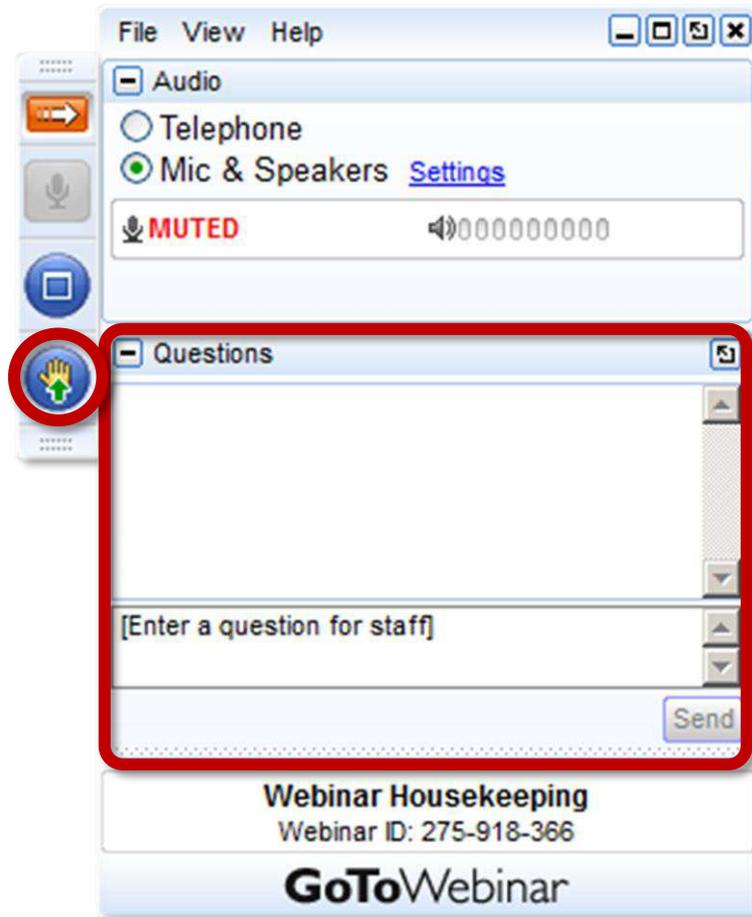
Join audio:

- Choose “Mic & Speakers” to use VoIP
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Submit questions and comments via the Questions panel

Note: Today’s presentation is being recorded and will be provided within 48 hours.

Asking Questions



Your Participation

- Please continue to submit your text questions and comments using the Questions Panel
- Please raise your hand to be unmuted for verbal questions.

Presentation Overview:

- Defining terms & describing models for integration.
- Why is there so much talk about integrating services?
- Outcomes associated with services integration.
- Components of Effective Implementation :
 - Care Coordination & Confidentiality
 - Care Pathways/Workflow
 - Team-based Care
 - Workforce Readiness
 - Factors Influencing Organization Change/Adoption of Integrated Health
- Questions/Discussion!



So Many Terms...So Much Happening!



Defining Our Terms

- How we define a “Term” determines how we structure beliefs & ultimately our behavior.
- Terms are at the core of how we think & act.
- Importantly, if policy makers, clinicians &/or administrators are not clear on the definition & source of their terms it is difficult to design or implement an integrated health model.



Integration Terms

Some Integrated Health Term Sources:

- **Research Literature-** "Collaborative Care"
- **Policy-** "Health Home"
- **Accrediting Bodies-** "Patient Centered Medical Home"
- **Provider Agencies-** "Pt. Centered Healthcare Home"



Defining Integrated Health...

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions

Integrated Care

Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Patient-Centered Care

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

Coordinated Care

The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care

A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Patient-Centered Medical Home

An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Mental Health Care

Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

From: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

Defining Integrated Health

“At the simplest level, integrated behavioral & physical health care occurs when mental health specialty & primary care providers work together to address the physical & behavioral health needs of their patients.”

“Integration can be bi-directional: either (1) specialty behavioral health care introduced into primary care settings, or (2) primary health care introduced into specialty behavioral health settings.”

Source: Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09- E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.



Why Integrate Behavioral Health & Primary Care?

Chronic illness is the number one health care problem
in the United States

- 45% of Americans have one or more chronic conditions.
- Over half of these people receive their care from 3 or more physicians.
- Treating these conditions account for 75% of direct medical care costs in the US.

Integration = Good Healthcare



**Superb Access
to Care**



**Patient Engage-
ment in Care**



**Clinical Infor-
mation Systems**



**Care Coordi-
nation**



Team Care



**Patient Feed-
back**



**Publicly
Available Infor-
mation**

Person-Centered/Seamless Integrated Care



Standard Framework for Integration

Referral		Co-Located		Integrated	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<i>Minimal Collaboration</i>	<i>Basic Collaboration at a Distance</i>	<i>Basic Collaboration On-Site</i>	<i>Close Collaboration On-Site with Some System Integration</i>	<i>Close Collaboration Approaching an Integrated Practice</i>	<i>Full Collaboration in a Transformed/ Merged Integrated Practice</i>
Behavioral health, primary care and other healthcare providers work:					
In separate facilities.	In separate facilities.	In same facility not same offices/clinic (e.g., separate waiting areas).	In same space within the same facility but separate work flows/teams.	In same space within the same facility regular teaming & cross staffing.	In same space within the same facility, sharing all practice space (one clinic/one team).



IH Outcomes



IH Outcomes: For People with Severe Mental Illnesses

“...consumers treated at PBHCI clinics had greater reductions in select indicators of risk for metabolic syndrome and several physical health conditions, including hypertension, dyslipidemia, diabetes, and cardiovascular disease.”

Source: RAND, 2013. Eval. SAMHSA Primary & Beh. Health Care (PBHCI) Grant Program: Final Report.



IH Outcomes: For Youth

- Benefits of IH were observed for interventions that target mental health problems. Although there was variability in effects across studies, these overall results enhance confidence that IH will lead to improved youth outcomes.
- Practice-based intervention using the 5 A's model (ask, advise, assess, assist, arrange) recommended by the US Public Health Service clinical practice guideline and the American Academy of Pediatrics showed to be effective especially for substance use disorders.

Source: J. Asarnow, M. Rozenman, J. Wiblin, BA, L. Zeltzer. (2015). Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child & Adolescent Behavioral Health A Meta-analysis *JAMA*

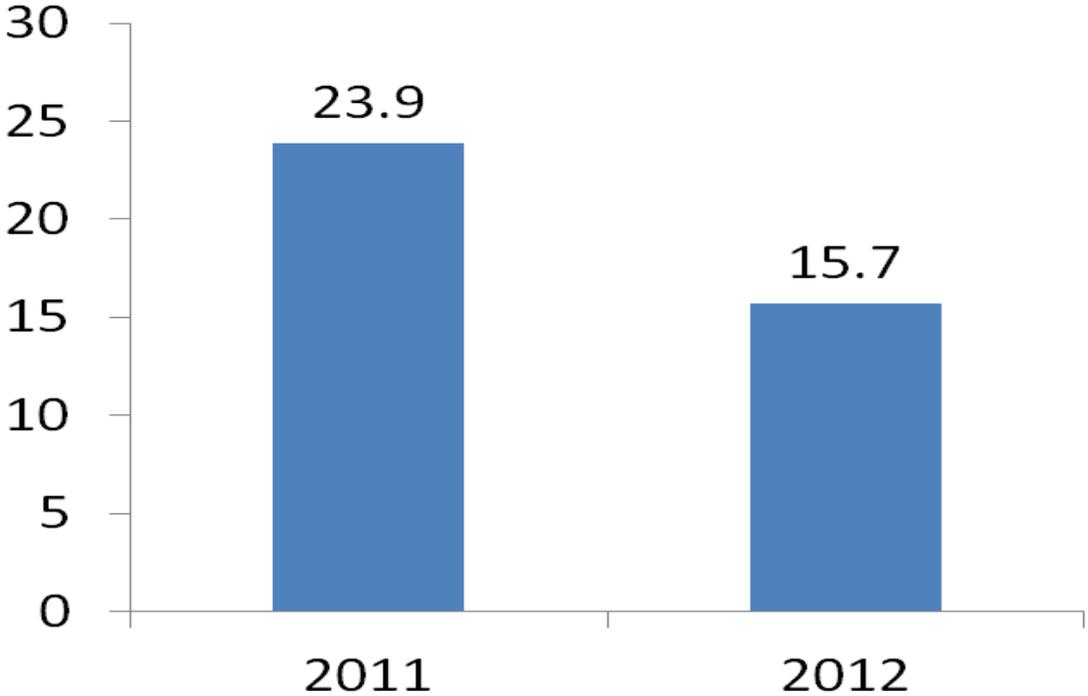


Outcomes

Reducing Hospitalization

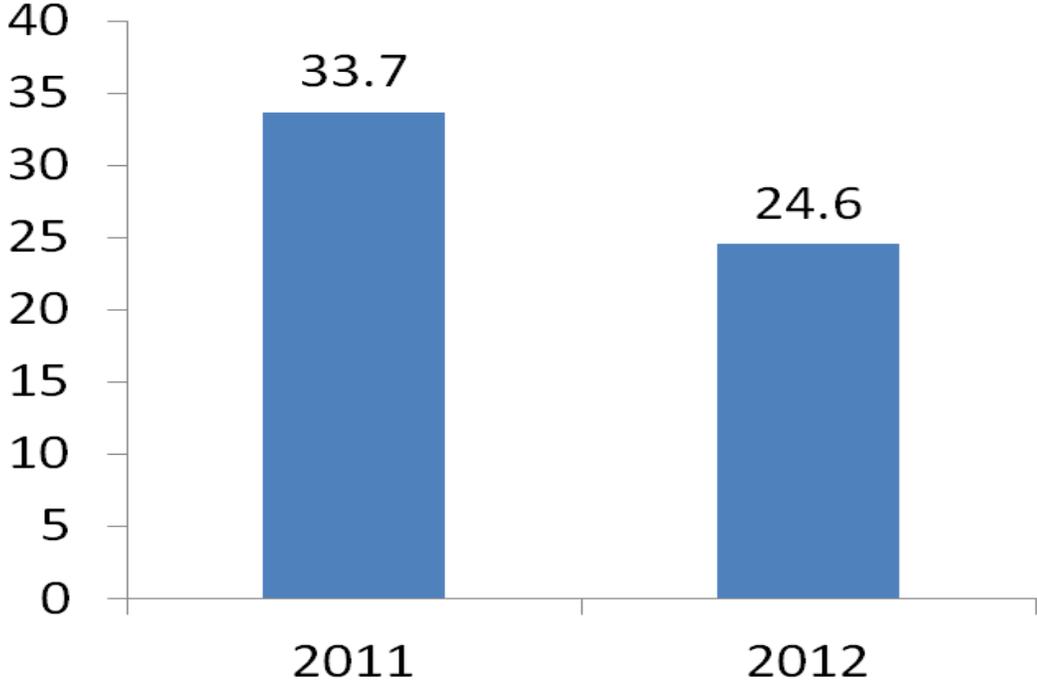
Source: Parks, J
See: http://www.integration.samhsa.gov/Joe_Parks_Envisioning_the_Future_of_Primary_and_Behavioral_Healthcare_Integration.pdf

% of Patients with at least 1 Hospitalization



Primary Care Health Homes

% of Patients with at least 1 Hospitalization



CMHC Healthcare Homes



Initial Estimated Cost Savings after 18 Months

Missouri Health Homes Total Saving

- 43,385 persons total served
- Cost Decreased by \$51.75 PMPM
- Total Cost Reduction \$23.1M

Source: Parks, J

See:http://www.integration.samhsa.gov/Joe_Parks,_Envisioning_the_Future_of_Primary_and_Behavioral_Healthcare_Integration.pdf



IH Outcomes: Do People Become Healthier with IH?

- Integrated Care “can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.”

Source: Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, & Behavioral Health Care Settings: Systematic Review and Meta-Analysis. *Am J Psychiatry* 2012;169:790-804.

- Over 30 RCT's showing IH improves health outcomes.

See: Blount: http://moo.pcpcc.net/files/organizing_the_evidence.pdf

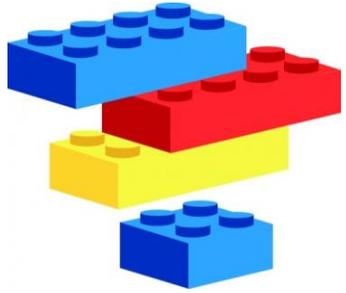
Importantly Consumers Like IH Approaches...

- For e.g. older adults reported greater satisfaction with mental health services integrated in primary care settings than through enhanced referrals to specialty mental health and substance abuse clinics.
- Pt engagement helps to drive health literacy and ultimately pt. “ownership”/responsibility for health behavior change.
- In the new marketplace the pt. has more choice about who to see so customer satisfaction matters...

Source: Chen H, Coakley EH, Cheal K, et al. (2006). Satisfaction with mental health services in older primary care patients. *Am J Geriatr Psychiatry*. Apr;14(4):371-9.



IH Components



- Care Coordination & Confidentiality
- Care Pathways/Workflows
- Team-based Care Approaches
- Factors Influencing Organization Change/Adoption of Integrated Health



Care Coordination Defined

“the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.



Perspectives on Care Coordination

Patient & Family

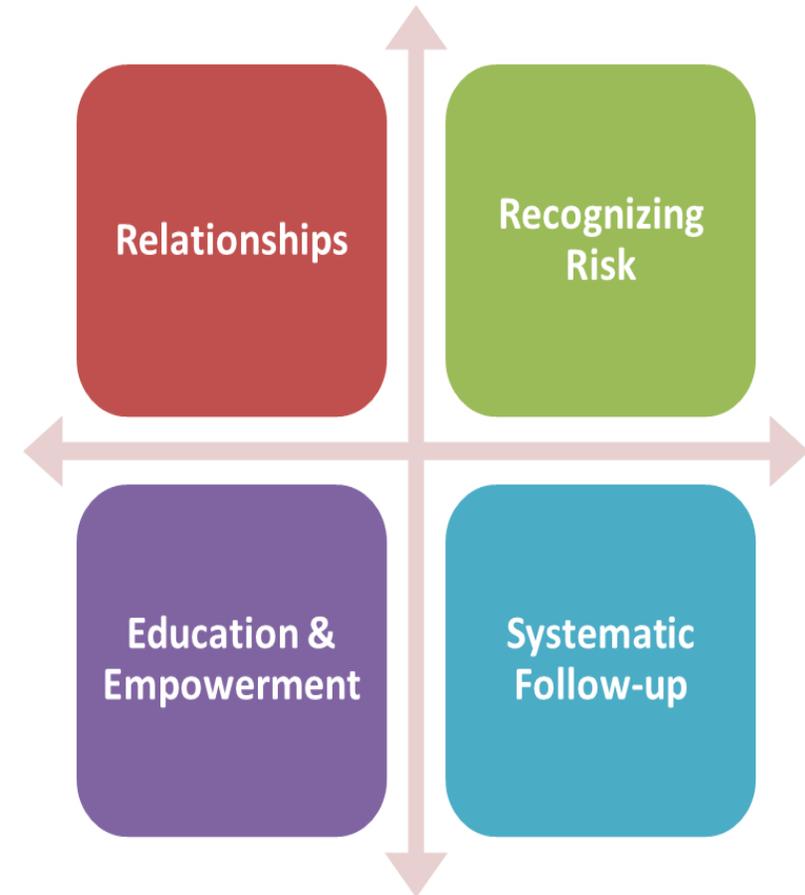
- How easy is it for me to get the care I/my loved one needs?

Healthcare Provider

- How easy is it for me to receive/share information & prevent/treat illness?

System Representatives & Payers

- How easy is it for me to know care is effective & efficient?



Source: McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

Confidentiality

Core Concepts in Confidentiality:

- Health Insurance Portability & Accountability Act of 1996 (HIPAA)
- 42 Code of Federal Regulations (CFR)
- State Mental Health & Substance Use Disorder Treatment Legislation

Core Administrative Elements:

- HIPAA – Organized Healthcare Delivery System
- HIPAA – Business Associates Agreement
- 42 CFR – Qualified Service Organizations
- Integrating Consent Forms

HIPAA The Organized Health Care Delivery System

- **A clinically integrated care settings in which individuals typically receive health care from more than one health care provider;**
 - **Hold themselves out to the public as participating in a joint arrangement; & Participate in joint activities that include at least one of the following:**
 - 1. Utilization Review**, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;
 - 2. Quality Assessment & Improvement Activities**, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or
 - 3. Payment Activities**, if the financial risk for delivering health care is shared; or
 - 4. Participation in A Group Health Plan, a Health Insurance Issuer or Health Maintenance Organization**



To Become an OHDS

- CEO's Declare they are naming the components of the system as such in a letter to partnering agency.
- Identify what the QI or Utilization shared activity.
- Include nature of the OHDS in each organization's privacy statement.
- Have reviewed by corporate attorneys with focus on state mental health code and 42CFR regulations.
- Joint agreement on how data will flow through care pathways.

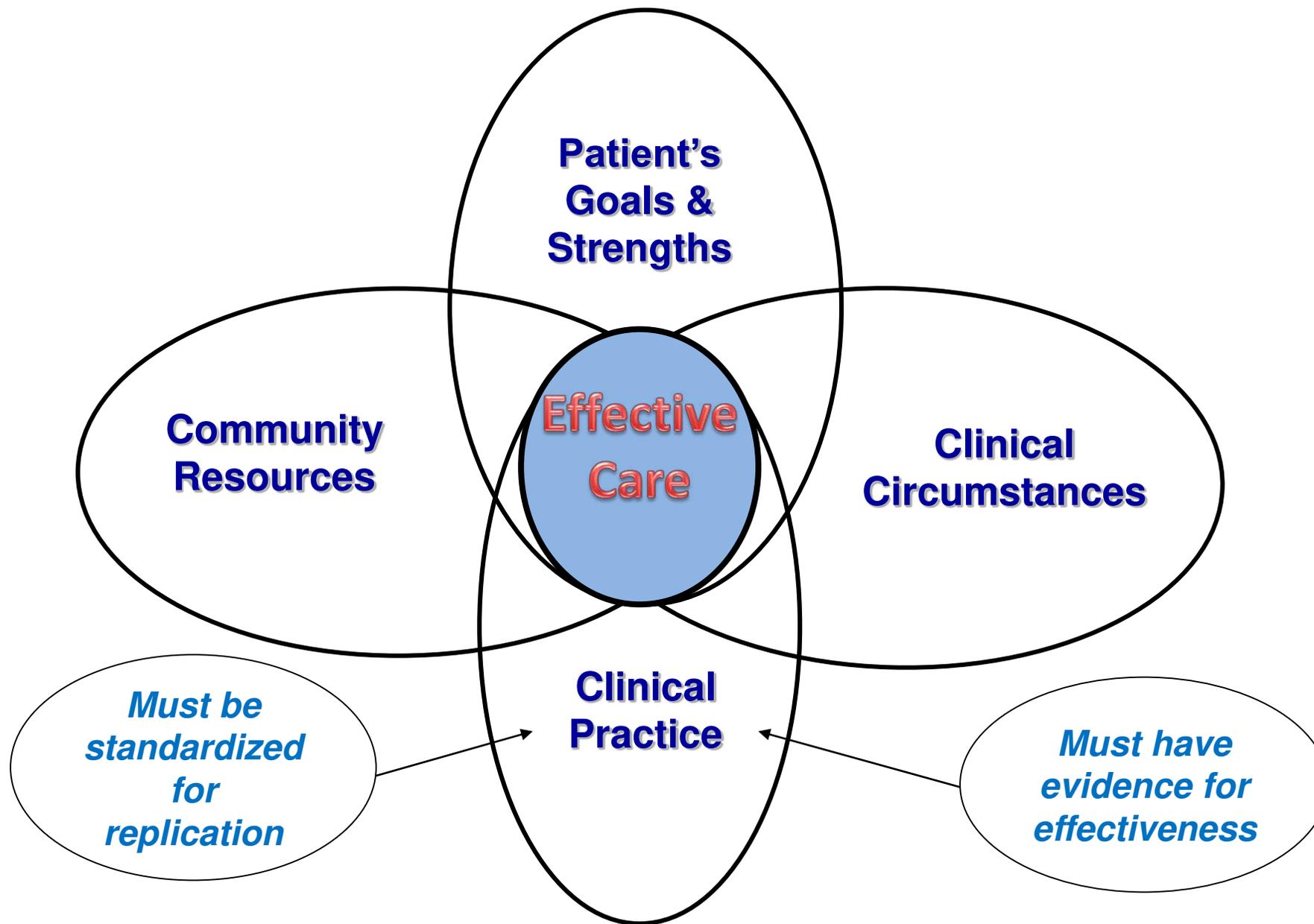
Integrated & Evidence-based Care Pathways

“The concept of '**integrated care pathways**' aims to shift clinicians & managers to thinking more about the '**patient journey**' ...

An **Integrated Care Pathway** aims to have:

- the **right people**,
 - in the **right order**,
 - doing the **right thing**,
 - at the **right time**,
 - with the **right outcomes**,
- & all with attention to the **patient experience.**”

Source: WHO, 2008 http://www.who.int/healthsystems/technical_brief_final.pdf



Clinical Pathway Components

A pathway where the...

Clinical Practices Workflow

(Evidence-based, Best, & Promising Practices Expressed in the Staff Workflow)

&

Consumer/Pt's Treatment Plan

(Their understanding/commitment to health behavior change)

&

Administrative Workflow

(Charting, billing, team huddles, care coor., etc....expressed in the Staff Workflow)

*intersect/are expressed to achieve the triple aim
(cost containment/population health/satisfaction)*

Clinical Practices Workflow Component

- Includes specific Mental Health, Substance Use Disorder, & Physical Health Screening, Assessment, & Treatment Practices protocols
- Each practice requires training & treatment to target measures
- Data must be captured in structured fields for reporting/dashboards & care coordination
- Concurrent/Collaborative Documentation is required

Consumer/Pt's Treatment Plan Component

- Health/recovery goals must be based on the person's stage of change/readiness for change for the conditions being treated
- Healthcare field is moving to monitoring at least quarterly progress on goals/treatment targets
- Treatment plan must be shared with all care providers either via:
 - Fax
 - Secure Email
 - In-person
 - Continuity of Care Document electronic transfer



Administrative Workflow?

- An orchestrated and repeatable pattern of staff behaviors designed to drive reliable/standardized billing, data collection, population health management, and ultimately outcomes.
- In other words, the behavioral patterns/routines staff engage in everyday when they come to work!
- Requires workflow analysis, policies, and protocols that are supported through one-on-one supervision and huddles.

Variation = Waste = Poor/Expensive Care

- The degree to which a clinic can work as a team and standardize clinical practice and admin. processes to reduce variation/waste will determine the quality of care provision and financial sustainability of the clinic
- Measuring processes and resulting outcomes is the only way to determine if a process is efficient and effective (or variable and wasteful)

Why does this matter?

“If you are not measuring a process you don’t know what you are doing.”

“If you are not measuring processes you can’t improve.”

“If you are not measuring processes you are operating blindly and therefore are at risk for delivering ineffective and wasteful care at best.”

*If you are not measuring your care provision and administrative processes you can not achieve **the triple aim** of population health management, cost containment , customer centered care ...
in other words survive in healthcare marketplace today.*

Team-base Care & Workforce Preparation



A Continuum of Healthcare Teams

- **Multi-disciplinary Team** = hierarchical, each role separate, some communication, parallel processes.
- **Inter-disciplinary Team** = interdependent, maintain distinct professional responsibilities & assignments, must make dramatic adjustments in their orientation to co-workers.
- **Trans-disciplinary Team** = shared decision making, every member can do everyone else's role if needed, one process, much communication.

Source: Cooper et al. (2003). The Interdisciplinary team in the management of chronic condition: Has its time come? RWJF.



The Inter-disciplinary Team:

People with distinct disciplinary training working together for a common purpose, as they make different, complementary contributions to patient-focused care.

Source: Leathard , A., ed. (1994). *Going Interprofessional: Working Together for Health & Welfare*. Routledge, London.



Adaptive Reserve

Borrill et al. found that teams with greater occupational diversity reported higher overall effectiveness and the innovations introduced by these teams were more radical and had significantly more impact both on the organization and on patient care.

Source: Borrill & Haynes (2000). Managers' lives. Stressed to kill. *Journal of Health Service*.10;110(5691):24-5.



The Team as an Emerging Standard of Care

“The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system.”

Source: Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.5.



Five Components of Effective Interdisciplinary Teams:

1. Defining appropriate team goals.
2. Clear role expectations for team members.
3. A flexible decision-making process.
4. The establishment of open communication patterns.
5. The ability of the team to “treat” itself.

Source: Leipzig, Hyer et al. (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline J Am Geriatr Soc 50:1141–1148.



What Competencies will be needed?

1. Interpersonal Communication
2. Collaboration & Teamwork
3. Screening & Assessment
4. Care Planning & Care Coordination
5. Intervention
6. Cultural Competence & Adaptation
7. Systems Oriented Practice
8. Practice Based Learning & Quality Improvement
9. Informatics

Source: Annapolis Coalition on Behavioral Health Workforce White Paper, “Core Competencies for Integrated Behavioral Health and Primary Care”



Engagement verses Activation

- An example of “engagement” is meeting with your doctor
- “Activation” is what you do after leaving your doctor’s office
- New health behavior increases with activation of self-management, especially with chronic conditions
- Three keys to activate self-management include:
 1. Person-centered planning based on existing strengths and supports
 2. Writing an IMPACT goal resulting from person-centered planning
 3. Implementing weekly actions plans to break goals into small successes



Writing an IMPACT goal

Creating a Whole Health Goal with **IMPACT**

A goal is something we want and are willing to work for. We do the work because of the benefits that come from accomplishing the goal. It is the potential benefits that motivate us to act.

Create a whole health goal that is concise, easy to review and will ultimately lead to success in creating new health habits. Does your goal statement answer these six IMPACT questions?

I mprove

Does accomplishing the goal improve the quality of my health and resiliency?

M easurable

Is the goal objectively measurable so I know if I have accomplished it?

For something to be measurable, it usually has to state an amount — how much, how often or how many one wants.

P ositively Stated

Is it positively stated as something new I want in my life?

It is more motivating to work toward getting something that you want than focusing on something that you want to get rid of, avoid or change.

A chievable

Is it achievable for me in my present situation and with my current abilities?

If you do not think your goal is achievable within the given time frame, you can either lower the scope or change the time frame.

C all forth Actions

Does it specify actions that I can take on a regular basis to create healthy habits or a healthier lifestyle?

A goal is something you work to achieve over a period of time; therefore there are actions you can take to achieve your goal.

T ime Limited

When do I plan to accomplish my goal?

The goal needs to be stated so that you know by when you plan to accomplish it.

If you answered 'no' to any of these questions, then revise your goal so it meets all six criteria for IMPACT.

This document was developed for SAMHSA Primary and Behavioral Health Care Integration grantees by the SAMHSA-HRSA Center for Integrated Health Solutions. Visit www.integration.SAMHSA.gov for more tools and resources on setting health goals.



The Organizational Components Impacted by Adoption of IH Models

1. Staffing
2. Building Design
3. Partnerships/Contracting
4. Financing
5. Clinical Practice
6. Health Information Technology
7. Quality Assurance & Improvement
8. Marketing/Customer Service



Factors Influencing Model Design Adoption

Many factors influence the adoption of integrated approaches including:

- 1. The Organization's Vision for Care Provision**
- 2. Organizational Capacity to Innovate**
- 3. Funding Design**
- 4. Health Information Infrastructure—**
organizational & state levels
- 5. Provider Network—**who does what, who gets along?
- 6. Location—**State, Urban, Rural



Model Components Vary in Difficulty

- Implementing discrete/structural model components was easier than changing roles and work patterns to use them.
- For example, many practices implemented disease registries, but were unable to reconfigure work processes to use them effectively for population management.
- Same-day scheduling and e-prescribing were far easier than developing care teams and population management.

Source: Paul A. Nutting, see <http://www.slideserve.com/kobe/the-patient-centered-medical-home-implications-for-health-policy-and-workforce-development>



Keys to Successful Implementation

- Shared Vision between Partners
- Change Management Technology
- Communication Plan
- Clear Statement of Work/Charge
- Work Plan Goals Detailing:
 - a. Action Steps
 - b. Accountability
 - c. Measures
 - d. Timelines
 - e. Resource Requirements



POLL QUESTION

What is your organization doing right now regarding IH?:

- a.) We are researching integration approaches.
- b.) We are in active discussion with healthcare network providers about how to integrate.
- c.) We have established data sharing agreements with network providers.
- d.) We have provided integrated health training to our staff.



Discussion/Questions?



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