Discussion Overview

1. Terms
2. Integration Drivers
3. Integration Designs
4. Integration Outcomes
5. Integration Training Needs:
   - University
   - Site
   - Student
6. Discussion/Questions
5 Most Common Responses to the Talk about Healthcare Today
So Many Terms…So Much Happening!
Huh?

Population Health Management
Care Management/Care Coordination
Quality Metrics
The Triple Aim (Satisfaction/Populations/Cost)
Data Dashboards
Registry
Health Information Exchanges
Measurement Specifications
Treat-to-Target
Stepped-care
Performance-based Contracting
Bundled Payments
Clinical Pathway
Workflow
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).

Coordination 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 (Utter 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)


integration.samhsa.gov
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.”

IH Drivers
The Triple Aim is…in Essence a Call for Care Integration

Targets identified by Don Berwick (former director of the Center for Medicaid/care Services & Institute for Healthcare Improvement) that new approaches to healthcare services provision should aim to achieve:

1. Improving the Health of Populations of People
2. Bending the Cost Curve
3. Improving the Patient’s Experience/Quality of Care

Integrated Care
Reconnection of the Head and the Body

Behavioral Health  Physical Health

Healthcare Integration is just rediscovering the Neck

--Partners in Health - Primary Care/County Mental Health Collaboration Toolkit, Integrated Behavioral Health Project (IBHP), October 2009
Integration: A New Initiative?

“The Body must be treated as a whole and not just a series of parts.”

--Hippocrates 300 BC
The 53 year lifespan for people with Serious Mental Illness is comparable with Sub-Saharan Africa.
Biggest Driver of IH

U.S. Healthcare Spending as a Percentage of GDP, 1960 - 2010

Source: OECD
Accessed 2012-09-10 18:20
Love it or Hate it, Out of Control Healthcare Costs Led to the Affordable Care Act
Benefits of the Affordable Care Act for Americans

- Improving quality & lowering healthcare costs
- Benefits for Women
  - Providing insurance options, covering preventive services, and lowering costs.
- Young Adult Coverage
  - Coverage available to children up to age 26.
- Strengthening Medicare
  - Yearly wellness visit and many free preventive services for some seniors with Medicare.
- Holding Insurance Companies Accountable
  - Insurers must justify any premium increase of 10% or more before the rate takes effect.
ACA Drivers of IH

- 10 Essential Benefits Requirement
- Medicaid Expansion
- Medicaid Health Home Models (section 2703)
- Accountable Care Models
- Managed Care Carve-in Models
- Industry Consolidation
- Payment Bundling linking Cost to Quality
Where the **States** Stand on Medicaid Expansion

28 States, DC, Expanding Coverage—January 27, 2015

Notes: Based on literature review as of 1/27/15. All policies subject to change without notice.

HHS has announced that states can obtain a waiver to use federal funds to shift Medicaid-eligible residents into private health plans. The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.
39 state Medicaid programs contract with comprehensive MCOs.

As of September 2014

Contracts with MCOs (39 states including DC)

Does not contract with MCOs (12 states)

SOURCE: KFF Medicaid Managed Care Market Tracker
As of October 2015, 19 states and the District of Columbia have a total of 27 approved Medicaid health home models.

States with Approved Health Home SPAs (number of approved health home models)

- Alabama, District of Columbia, Idaho, Iowa (2), Kansas, Maine (2), Maryland, Michigan, Missouri (2), New Jersey (2), New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Vermont, Washington, West Virginia, Wisconsin

Note that Oregon has withdrawn its Medicaid health home state plan amendment and is no longer providing services under a 2703 SPA.
Accountable Care Orgs. – National Perspective
Driver: New Accreditation Standards for the Patient Centered Healthcare Home

- Superb Access to Care
- Patient Engagement in Care
- Clinical Information Systems
- Care Coordination
- Team Care
- Patient Feedback
- Publicly Available Information

Person-Centered Healthcare Home
Driver: Need for 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.”

Wagner’s Chronic Care Model

The Four Quadrant Model

• Conceptual framework for designing integrated programs.
• Offers guidance to determine which setting can provide the most appropriate care.
• Defines what care people need and where care is best delivered based on the severity of the person’s behavioral health and physical health needs.
• Describes the need for a bi-directional approach, addressing the need for primary care services in behavioral health and visa versa.
**Quadrant II**

<table>
<thead>
<tr>
<th>BH</th>
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- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

**Quadrant IV**

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- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

**Quadrant I**

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- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

**Quadrant III**

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<th>BH</th>
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- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports
# Standard Framework for Integration

<table>
<thead>
<tr>
<th>Referral</th>
<th>Co-Located</th>
<th>Integrated</th>
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<tbody>
<tr>
<td><strong>Key Element:</strong> Communication</td>
<td><strong>Key Element:</strong> Physical Proximity</td>
<td><strong>Key Element:</strong> Practice Change</td>
</tr>
<tr>
<td>Level 1 Minimal Collaboration</td>
<td>Level 2 Basic Collaboration at a Distance</td>
<td>Level 3 Basic Collaboration On-Site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 4 Close Collaboration On-Site with Some System Integration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 5 Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 6 Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

**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).
Key Components of the Pt. Centered Medical Home

- Ongoing relationship with a personal physician who is trained to provide first contact, continuous and comprehensive care
- An informed and activated patient
- Whole person orientation
- Care is co-managed by a team who collectively take responsibility to provide or arrange for care
- Levels of care include acute, chronic and preventive
- Span of life care
- Care interfaces with family and community context as appropriate
- Care is Coordinated and/or Integrated
- Quality and Safety are hallmarks
- Enhanced Access to care is available
- Payment appropriately recognizes the added value

Core Components of Integrated Models

**Person-centered care.** Basing care on the individual’s preferences, needs, and values. With person-centered care, the client is a collaborative participant in healthcare decisions and an active, informed participant in treatment itself.

**Population-based care.** Strategies for optimizing the health of an entire client population by systematically assessing tracking, and managing the group’s health conditions and treatment response. It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.

**Data-driven care.** Strategies for collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment. Validated clinical assessment tools monitor response to treatment and information systems such as registries track the data over time.

**Evidence-based care.** The best available evidence guides treatment decisions and delivery of care. Both the behavioral health agency and its health provider partner must deliver evidence-based services.

IH Core Components for Children with BH Conditions

1. FAMILY AND YOUTH-GUIDED TEAMS WITH CARE COORDINATION CAPABILITY. A coordinator is designated to communicate, coordinate, & educate. Family members and youths are considered important participants and advisors throughout the process.

2. INDIVIDUALIZED AND COORDINATED CARE PLANS. Care plans are individualized:& guided by family/youth input, including their values, preferences, & available resources.

3. USE OF EVIDENCE-BASED GUIDELINES. Use EBP’s, screening, & assessment tools, follow the guidance of the *Bright Futures initiative of the American Academy of Pediatrics* for well child visits until the age of 21.

4. ESTABLISHED & ACCOUNTABLE RELATIONSHIPS WITH OTHER ENTITIES. Organizations establish relationships with outside entities including formal agreements on topics such as communication standards, wait times, or responsibility for development of care plans.

5. DATA-INFORMED PLANNING. Organizations have clinical information systems that support proactive planning & informed decision making on both individual and population levels.

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.”

IH Outcomes

Results
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.”


Over 30 RCT’s showing IH improves health 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. No similar benefit of PBHCI was observed for other indicators, including triglycerides, obesity, and smoking. Consistent with other studies of integrated care not directly targeting changes to BH service delivery…no reliable benefit of PBHCI on indicators of BH.”

IH Outcomes: For Youth

Benefits of IH were observed for interventions that target MH problems. Although there was variability in effects across studies, these overall results enhance confidence that IH will lead to improved youth outcomes.

Results were weaker for S/A…only one large trial (N = 2709) indicating a significant effect.

This trial included a 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

IH Outcomes: Does IH Lower Cost?

• Depression treatment in primary care for those with diabetes correlated with an $896 lower total health care cost over 24 months\(^2\)

• Medical use decreased 15.7% for those receiving behavioral health treatment while controls who did not get behavioral health medical use increased 12.3%\(^1\)

• Depression treatment in primary care $3,300 lower total health care cost over 48 months\(^3\)

Sources:
Cost Savings & Accountable Care Organizations

- 20 ACOs in the Pioneer ACO Model & 333 Medicare Shared Shavings Program ACOs generated more than $411 million in total savings in 2014.

- 97 ACOs qualified for shared savings payments of more than $422 million by meeting quality standards.

- The results also show that ACOs with more experience in the program tend to perform better over time.

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…

IH Training
Common Provider Organization Integration Needs

• Defining & communicating the IH vision
• Investigating & implementing best practices/strategies
• Designing the business model
• Finding a BH or PC partner or hiring your own BH/PC staff
• Bridging the cultural divide between PC & BH
• Developing policies & procedures
• Clarifying funding sources & maximizing profit
• Est. or strengthening networks of care partnerships
• Developing BH registries & data collection/sharing to support clinician/administrator decision making
• Conducting work flow analysis to leverage time & cost while making same-day access a reality
• Training staff in BH interventions & team based approaches to care coordination
Defining & Starting the Integration Journey

- Hard to know where to go unless you know where you are and where you want to go!

- The same is true for organizations

- Important that organizations clarify their current level of integration and vision for further integrating by using organizational level of integration measures
IH Organizational Self-Assessment Tools

Several free, reliable, OSA Tools are available including:

✓ The Integrated Practice Assessment Tool (IPAT)

✓ Behavioral Health Integration Capacity Assessment (BHICA)

✓ Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration (OATI)
Keys to Successful Implementation

• Shared Vision between Network Partners
• Change Management Technology
• Communication Plan
• Clear Statement of Work/Charge
• Work Plan Goals Detailing:
  a. Tasks
  b. Accountability
  c. Measures
  d. Timelines
  e. Resource Requirements
IH Staff Competencies

1. Interpersonal Communication
2. Collaboration & Teamwork
3. Screening & Assessment
4. Care Planning & Care Coordination
5. Evidence-based Intervention Skills
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”
5 A’s Model is Still the Foundation for Clinical Engagement

1) Assess/Screen
   Risk factors, behaviors, symptoms, attitudes, preferences

2) Advise
   Specify options for treatment, how symptoms can be decreased, & how functioning & quality of life can be improved

3) Agree
   Collaboratively select goals based on patient interest and motivation to change

4) Assist
   Provide information, teach skills, and help problem-solve barriers to reach goals

5) Arrange
   Specify plans for follow-up (visits, phone calls, email reminders)

Personal Action Plan
1. List goals in behavioral terms.
2. List strategies to change health behaviors.
3. Specify follow-up plan.
4. Share the plan with the healthcare team.
University Field Placement Staff Needs

- Understanding of Field Placement Site(s) Level of Integration
- Protocols Demonstrating Evidence-based Care Pathways
- Health IT driving Population Health Management Approaches
- Team-based Approach to Care Provision
- Opportunities for Student to Shadow All Disciplines
- Opportunities for Students to Provide Discipline Relevant Interventions
Field Placement Supervisor Needs

Assurance that:

• Student has Foundational Knowledge Regarding the Screening & Assessment of BH & PC Conditions

• Student has Motivational Interviewing, Trauma Informed Care, & SBIRT Knowledge

• Student can Take Part in IH Project (e.g., developing an IH policy and/or procedure)

Plus if:

• Student has Experience using an EMR

• Student Understands Documentation & Billing Protocols
Student Needs

- Experience with Patient Role-plays in Class Room
- “Cheat Sheets”:
  - Explaining Various Screening & Assessment Tools
  - Language Commonly Used by Various Disciplines
  - Common Lab Values
  - Common Medications
- Ability to Shadow All Disciplines
- Ability to co-lead groups, provide brief interventions, longer-term psychotherapy interventions, &/or complete physicals (i.e., engage in their clinical discipline)
- Education about Social Determinants of Health & Disparities of Care
- Mentorship
- More Experience with Substance Use Disorders Treatment
- More Experience with Proper Documentation
Team-based Care Resources


Change Management
References/Useful Resources

• A Sense of Urgency (2008). John P. Kotter
• The Heart of Change (2002). John. P. Kotter
• Thinking for a Change. (2003). John C. Maxwell
Further Reading/Resources


http://www.integration.samhsa.gov/ (Great resource on everything integration)

http://www.integratedcareresourcecenter.com/ (Website detailing what is happening with health reform in each state)

http://www.chcs.org/ (Website focused on publicly funded healthcare and the transformations underway)

http://www.h2rminutes.com/main.html (Updates on the ACA for professions—great site to sign up for email notices)

http://integrationacademy.ahrq.gov/atlas (1. Framework for understanding measurement of integrated care; 2. A list of existing measures relevant to integrated behavioral health care; & 3. Organizes measures by the framework and by user goals to facilitate selection of measures).
Further Reading/Resources

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare; Institute for Health Technology Transformation
http://www.exerciseismedicine.org/assets/page_documents/PHM%20Roadmap%20HL.pdf

CREEPING AND LEAPING FROM PAYMENT FOR VOLUME TO PAYMENT FOR VALUE Webpage


Seven Steps to Performance-based Services Acquisition/Contracting
http://159.142.160.6/comp/seven_steps/index.html

CMS Innovation Center: Health Care Payment Learning and Action Network

Partnering w/ Schools for MH: A Guidebook
Thank you!

Jeff Capobianco
Jeffc@thenationalcouncil.org

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