Introduction to Primary & Behavioral Healthcare Services Integration

October 21, 2015

Jeff Capobianco, PhD
Learning Objectives

1) What are the benefits of BH/PH integration: For health services and systems? For Consumers?
2) What's the current status/pace of BH/PH service integration?
3) How is integration currently occurring: models, methods, service configurations?
4) What special considerations and concerns exist for integrating services within a managed care environment?
Presentation Objectives

1. Defining Integrated Health
2. Integrated Health Program Components & Associated Outcomes
3. A Standard Framework for Understanding Integrated Care
4. Common needs identified by agencies engaged in IH
5. Questions/Discussion
So Many Terms...So Much Happening!
5 Most Common Responses to Health Care Services Today…
Defining Integrated Health...

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

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 (Unutzer 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 Unutzer for advice on organizing this illustration

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.”

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

Driver: New Market Designs

State Market Places

Carve in / Carve Out

Medicaid Expansion

Capitation

Accountable Care Organizations

Agency Consolidations

Parity Laws

Health Information Technology

Health Homes
Driver: The Healthcare Home

1. Superb Access to Care
2. Patient Engagement in Care
3. Clinical Information Systems
4. Care Coordination
5. Team Care
6. Patient Feedback
7. 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 and 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, and all with attention to the patient experience.”

High Level 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.

**Source:** Beh Health Homes for People with MH & SA, 2012.  
Core Components Cont...

- Payment Structures
- Health Information Technology/Data Sharing
- Partnering/Partnering Strategies
- Market Place Competition/Coopetition
- Development of Interdisciplinary Teams
- Tracking/Linking Quality Metrics to Cost
- Development of Wellness Programming
- Brand Recognition/Change
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 PBHCl 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 PBHCl 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 PBHCl on indicators of BH.”

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 months²

• 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 months³

Sources:
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…

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.
Behavioral Health and Physical Health Risk/Status

**Quadrant II**

BH ↑  PH ↓
- 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**

BH ↑  PH ↑
- 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

**Quadrant I**

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

**Quadrant III**

BH ↓  PH ↑
- 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

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.
# Standard Framework for Integration

<table>
<thead>
<tr>
<th>Referral</th>
<th>Co-Located</th>
<th>Integrated</th>
</tr>
</thead>
<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&lt;br&gt;Minimal Collaboration</td>
<td>Level 2&lt;br&gt;Basic Collaboration at a Distance</td>
<td>Level 3&lt;br&gt;Basic Collaboration On-Site</td>
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<tr>
<td>Level 4&lt;br&gt;CLOSE Collaboration On-Site with Some System Integration</td>
<td>Level 5&lt;br&gt;CLOSE Collaboration Approaching an Integrated Practice</td>
<td>Level 6&lt;br&gt;CLOSE Full Collaboration in a Transformed/Merged Integrated Practice</td>
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## Behavioral health, primary care and other healthcare providers work:

<table>
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<tr>
<th>Referral</th>
<th>Co-Located</th>
<th>Integrated</th>
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<tbody>
<tr>
<td>In separate facilities.</td>
<td>In separate facilities.</td>
<td>In same space within the same facility, sharing all practice space.</td>
</tr>
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</table>
Poll Question

<table>
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<tr>
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How would you rate your agency’s current level of integration?

- a. Level 1
- b. Level 2
- c. Level 3
- d. Level 4
- e. Level 5
- f. Level 6
<table>
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<tr>
<th>Domains of Integration</th>
<th>Level 1: Minimal Collaboration</th>
<th>Level 2: Basic Collaboration at a Distance</th>
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<td>Consumer Access to Primary &amp; Behavioral Health Services</td>
<td>Two front doors; consumers go to separate sites and organizations for services</td>
<td>Two front doors; clients supported with transportation &amp; coordination of scheduling</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Same reception; some joint service provided with two providers on site with some overlap</td>
<td>One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model</td>
</tr>
<tr>
<td>Clinical Services Coordination</td>
<td>Separate and distinct services (i.e., two Rx'ers and treatment plans); Clinicians rely on client for health information from providers seen outside of their service</td>
<td>Separate and distinct services with occasional sharing of treatment plans for consumers with high/urgent Behavioral and Physical Health Care needs</td>
<td>Two physicians prescribing with consultation; two treatment plans but routine sharing/coordination regarding individual consumers; Beh/Primary Care staff have protocols for services coor.</td>
<td>Two physicians prescribing same treatment plan integration, but not consistently with all shared consumers</td>
<td>Two physicians prescribing same treatment plan integration, but not consistently with all shared consumers</td>
<td>One treatment plan with all consumers, one site for all services; ongoing team consultation between providers; one set of lab work;</td>
</tr>
<tr>
<td>Funding</td>
<td>Separate systems and funding sources, no sharing of resources</td>
<td>Separate systems and funding sources, sharing of financial information</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding with shared on-site expenses, shared staffing costs and infrastructure</td>
<td>Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility</td>
</tr>
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</table>
## Collaboration Continuum between Primary & Behavioral Healthcare

### Levels of Integration

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</table>

#### Domains of Integration

<table>
<thead>
<tr>
<th>Organizational Governance &amp; Infrastructure</th>
<th>Use of Evidence-Based Practices (EBP's)</th>
<th>Management of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate systems with little to no collaboration; consumer is left to navigate the chasm</td>
<td>Individual EBP’s implemented in each system;</td>
<td>Separate data systems, often paper based, little if any sharing of data; no focus on population management</td>
</tr>
<tr>
<td>Separate systems with little to no collaboration; consumer is left to navigate the chasm</td>
<td>Two providers, some sharing of EBP information but responsibility for care cited in one clinic or the other</td>
<td>Separate data systems, often paper based; sharing of data via fax or secure email for high/utilizers; no focus on population management</td>
</tr>
<tr>
<td>Two governing Boards; line staff work together on individual cases; policies and procedures take into consideration care integration</td>
<td>Two providers, more formal sharing of information (e.g., cross training/brown bag lunch sharing) but responsibility for care cited in one clinic or the other</td>
<td>Separate data systems; charting in two records; staff with access to both records; some discussion of population management high cost/use clients; little to no QI process</td>
</tr>
<tr>
<td>Two governing Boards with Executive Director collaboration on services typically for high need/utilizing consumers</td>
<td>Some sharing of EBP’s around high need/utilizers; agreed upon process for ongoing sharing of knowledge between providers</td>
<td>Separate systems; well defined consent and data sharing process; dashboards for population management for high cost/use clients; QI process not routinely used in response to data findings</td>
</tr>
<tr>
<td>Two governing Boards that meet together periodically to discuss mutual issues and strategic planning</td>
<td>Sharing of EBP’s across systems; joint monitoring of health conditions for low and high need/utilizing consumers; cross-site protocols for EBP provision</td>
<td>Separate data systems, some individual case collaboration; some aggregate data/population level data sharing; registry in development; all clients reviewed via dashboards for pop management; QI process in use</td>
</tr>
<tr>
<td>One Board with equal representation from each partner; Board members include consumers of services</td>
<td>Use of same EBP’s for example use of validated screening and assessment tools of BH and PC; Motivational Interviewing, disease pathway protocols, etc. provided for all consumers</td>
<td>Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; clinical data registry in place for managing population for all clients, robust QI process for response to data findings</td>
</tr>
</tbody>
</table>
Common Integration Needs

- Defining & communicating the vision
- Investigating best practices/strategies
- Designing the business model
- Finding a BH or PC partner or hiring your own
- Bridging the cultural divide between PC & BH
- Developing policies & procedures
- Clarify what data to collect
Common Integration Needs

- 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
Keys to Success

• Shared Vision between Partners
• Change Management Technology
• Communication Plan
• Clear Statement of Work/Charge
• Work Plan Detailing: Tasks, Accountability, Measures, Timelines, & Resources Needed
• Coaching from Experts who have made the journey ahead of you
Linking Quality Metrics to Cost...the next Frontier
Will Financing for this practice area change?

In selected provider arrangements, Managed Care Orgs. will be transitioning and supporting financial risk, accountability and utilization management practices.

Provider Compensation Continuum
(Level of Financial Risk)

Source: Rhonda J Robinson Beale, M.D.
Optum Chief Medical Officer, External Affairs
### Simple Bundling Logic Model

<table>
<thead>
<tr>
<th>Demographic &amp; Condition</th>
<th>Level of Service Criteria/Cost</th>
<th>Service Bundle</th>
<th>Length of Care/Time to Tx</th>
<th>Target Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>Low Intensity</td>
<td>Medication Services</td>
<td>Low Intensity 0-9 Months</td>
<td>DLA 20 Target</td>
</tr>
<tr>
<td>Male</td>
<td>Moderate Intensity</td>
<td>Care Management</td>
<td>Moderate Intensity 9-12 Months</td>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>Substance Addicted</td>
<td></td>
<td>Supported Employment</td>
<td>High Intensity 12-18 Months</td>
<td>BP w/in Normal Range</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td>Smoking Cessation Services</td>
<td></td>
<td>Engagement/Willingness to take Medication</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td>Housing Services</td>
<td></td>
<td>Appt Kept Rate</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
<td></td>
<td>Hosp. &amp; ED Use</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Housing Status</td>
</tr>
</tbody>
</table>
Choose Condition: High Blood Pressure (BP)

Define Population: Diagnosis, Screening/Assessment Scores

Define Services: BP Screening at intake/quarterly; Referral & Coordination w/ Primary Care & Pharmacy

Episode Length of Time: 9 months

Calculate Cost: How much on average would it cost to treat this episode of care?
Case Rate Example

[Total Cost divided by (Number of Patient Days in an Episode x Number of Patients)] times 365

Total Cost for High BP Care Coor: $50,000
• Number of Patient Days in an Episode: 180
• Number of Patients: 100/year
• Case Rate Per Member Per Day: $3 PMP Month: $84 PMP Year: $1014

Source: Adapted from R. Manderscheid; Talk Titled: Intro. to Case Rates & Capitation Rates
Questions?
Change Management
References/Useful Resources

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
Thank you!

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Jeffc@thenationalcouncil.org

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