

Introduction to Primary & Behavioral Healthcare Services Integration

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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



5 Most Common Responses to Health Care Services Today...



The element of
CONFUSION

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)

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)

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).

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.



The Triple Aim is...in Essence a Call for Care Integration

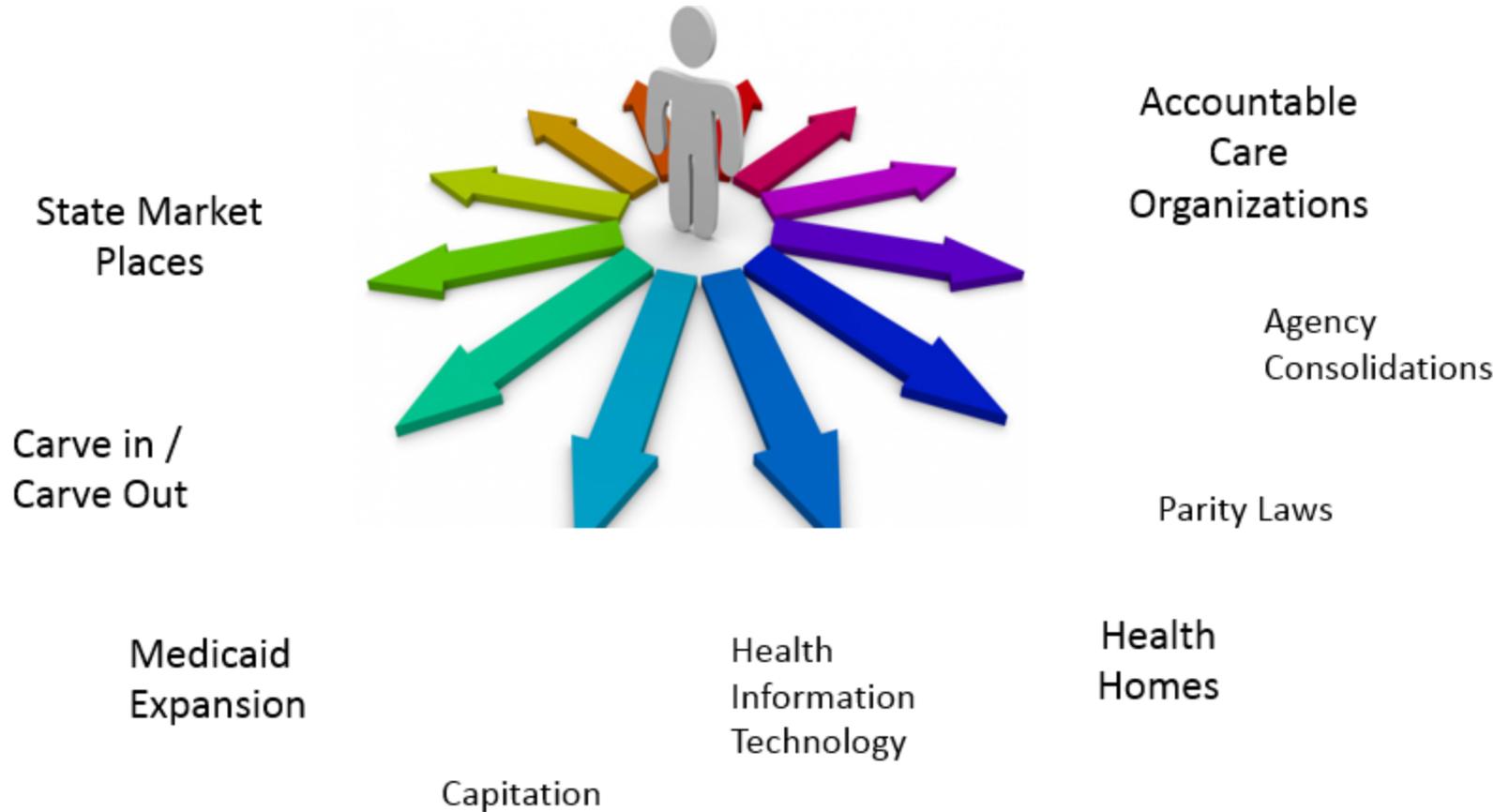
Targets identified by Don Berwick (former director of the Center for Medicaid/care Services & Institute for Healthcare Improvement) that new approaches to healthcare services provision should aim to achieve:

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

Source: Berwick, Nolan, & Whittington (2008).
The Triple Aim: Care, Health, And Cost.
Health Affairs. vol. 27 no.3, 759-769.



Driver: New Market Designs



Driver: The Healthcare Home



**Superb
Access to
Care**



**Patient
Engage-
ment in
Care**



**Clinical
Infor-
mation
Systems**



Care Coordination



Team Care



**Patient
Feed-back**



**Publicly
Available
Infor-
mation**



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.”

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



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.

http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf



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.”

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



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.”

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



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:

1. Chiles et al.(1999). Clinical Psychology. ;6:204–220.
2. Katon et al.(2006). Diabetes Care. ;29:265-270.
3. Unützer et al. (2008)., American Journal of Managed Care 2008;14:95-100.



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.



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.



High
↑
Behavioral Health Risk/Status
↓
Low

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

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
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

Low

Physical Health Risk/Status →

High



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 necessarily same offices.	In same space within the same facility.	In same space within the same facility (some shared space).	In same space within the same facility, sharing all practice space.



Poll Question

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

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



Collaboration Continuum between Primary & Behavioral Healthcare

Levels of Integration

Domains of Integration

	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>
Consumer Access to Primary & Behavioral Health Services	Two front doors; consumers go to separate sites and organizations for services	Two front doors; consumers go to separate sites; clients supported w/ transportation & coordination of scheduling	Separate reception, but accessible at same site cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers on site with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Clinical Services Coordination	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	Separate and distinct services with occasional sharing of treatment plans for consumers with high/urgent Behavioral and Physical Health Care needs	Separate and distinct services and treatment plans; two physicians (i.e., psychiatry & primary care) prescribing; Beh staff attend some appts at primary care	Two physicians prescribing with consultation; two treatment plans but routine sharing/coordination regarding individual consumers; Beh/Primary Care staff have protocols for services coor.	Two physicians prescribing same treatment plan integration, but not consistently with all shared consumers	One treatment plan with all consumers, one site for all services; ongoing team consultation between providers; one set of lab work;
Funding	Separate systems and funding sources, no sharing of resources	Separate systems and funding sources, sharing of financial information	Separate funding systems; both may contribute to one project with goal of shared funding	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility



Collaboration Continuum between Primary & Behavioral Healthcare

Levels of Integration

	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>
Organizational Governance & Infrastructure	Separate systems with little to no collaboration; consumer is left to navigate the chasm	Separate systems with little to no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases; policies and procedures take into consideration care integration	Two governing Boards with Executive Director collaboration on services typically for high need/utilizing consumers	Two governing Boards that meet together periodically to discuss mutual issues and strategic planning	One Board with equal representation from each partner; Board members include consumers of services
Use of Evidence-Based Practices (EBP's)	Individual EBP's implemented in each system;	Two providers, some sharing of EBP information but responsibility for care cited in one clinic or the other	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	Some sharing of EBP's around high need/utilizers; agreed upon process for ongoing sharing of knowledge betw providers	Sharing of EBP's across systems; joint monitoring of health conditions for low and high need/utilizing consumers; cross-site protocols for EBP provision	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
Management of Data	Separate data systems, often paper based, little if any sharing of data; no focus on population management	Separate data systems, often paper based; sharing of data via fax or secure email for high/utilizers; no focus on population management	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	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	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	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

Domains of Integration



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

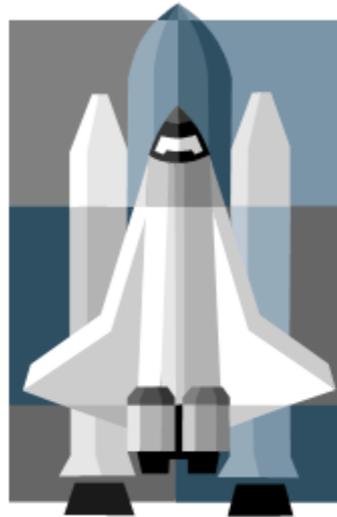


Keys to Success

- 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

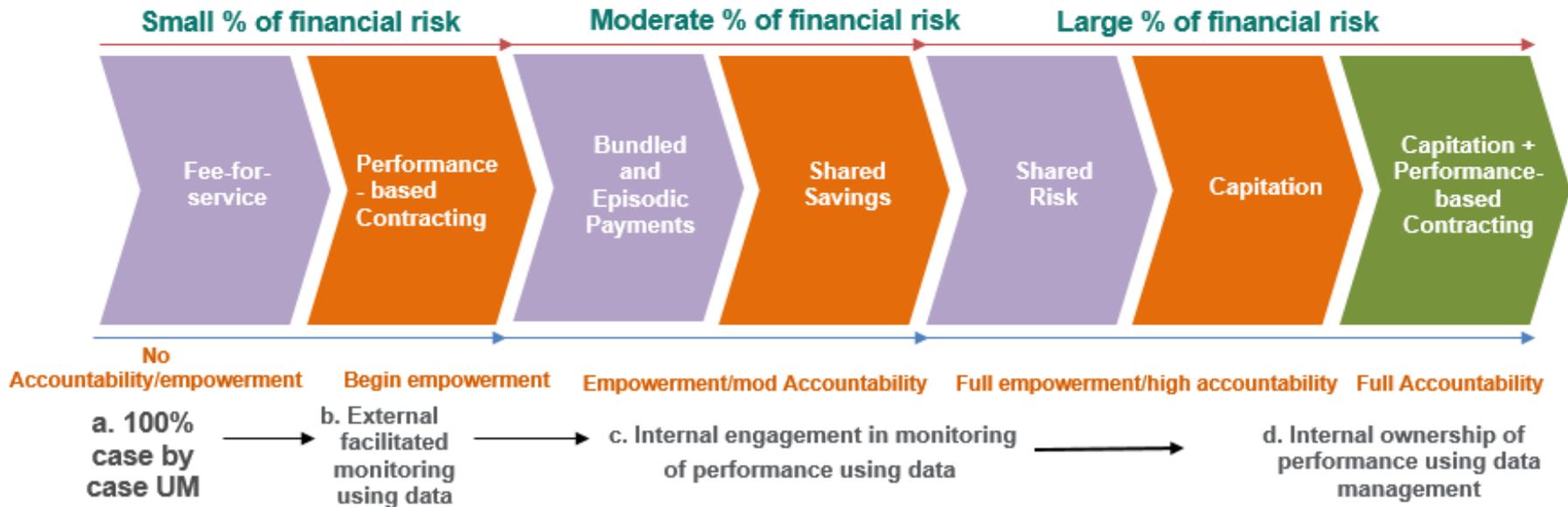


Will Financing for this practice area change?

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

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



Case Rate Example

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

- **Waterman Jr., Robert H., Peters, Thomas J., and Julien R. Phillips. (1980). "Structure is not organization." *Business Horizons* 23, no. 3: 14.**
- **Managing Transitions: Making the Most of Change, 2nd Edition (2003). William Bridges.**
- **The Advantage (2012). Patrick Lencioni.**
- **Our Iceberg is Melting: Changing & Succeeding Under Any Conditions (2005). John P. Kotter & Holger Rathgeber.**
- **A Sense of Urgency (2008). John P. Kotter**
- **The Heart of Change (2002). John. P. Kotter**
- **Thinking for a Change. (2003). John C. Maxwell**
- **Why Some Ideas Die and Other Stick: Made to Stick. (2008). Chip & Dan Heath**



Further Reading/Resources

- Felt-Lisk, S. & Higgins, T. (2011). Exploring the Promise of Population Health Management Programs to Improve Health. Mathematica Policy Research Issue Brief.
http://www.mathematica-mpr.com/publications/pdfs/health/PHM_brief.pdf
- Parks, J., et al. (2014) Population Management in the Community Mental Health Center-based Health, Center for Integrated Health Solutions
Homeshttp://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf
- <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
<https://www.thenationalcouncil.org/capitol-connector/2014/09/creeping-leaping-payment-volume-payment-value/>
- Guide http://www.thenationalcouncil.org/wp-content/uploads/2014/09/14_Creeping-and-leaping.pdf
- Workbook <http://www.thenationalcouncil.org/wp-content/uploads/2013/10/National-Council-Case-Rate-Tool-Kit.pdf>
- 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
<http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>



Thank you!

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