Bi-Directional Integration: What Degree of Integration is Needed for Success – Linking Indiana Integration Principles to National Models
What Degree of Success is Needed from the Affordable Care Act Perspective?

**Goal**: enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness

CMS expects that use of the health home service delivery model will result in

- lowered rates of emergency room use,
- reduction in hospital admissions and re-admissions,
- reduction in health care costs,
- less reliance on long-term care facilities, and
- improved experience of care and quality of care outcomes for the individual
Getting There: Benefits for the Newly Eligible

- Essential benefits include mental health and substance use treatment
- MH and SUD must be offered at parity with medical/surgical benefits

This means...

- ...Most members of the safety net will have coverage, including mental health and substance use disorders
Delivery System Redesign – Indiana Principles for Integration, Health Homes and Integration
Indiana Integration Principles

- A holistic approach to serving humans when it comes to health care and quality of life that includes recovery principles
  - Empowering individuals to improve their overall health status and quality of life
  - Emphasizing life style change that promotes high levels of personal resiliency
- Holistic assessment process that identifies a person’s needs and strengths, completed by a multi-disciplinary team of professionals
- Emphasis on teaching health care prevention as a critical component to improving and sustaining health and wellbeing
Indiana Operational Principles

- Multidisciplinary teams
- “Real time” communication OR
- “Timely linkage” between team for care coordination
- Co-location may not be enough!
Other Indiana Principles

• Use of Evidence Based Practices
• Continuous quality improvement and the use of data – Second webinar topic
The Holistic Approach and Recovery Principles and the Health Home/Integration Structure
Defining the 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
Superb Access to Care/Patient Engagement

• **Recovery Relevance of these Elements**
  • **Same Day/Next Day Access**
    • The services I need, when I need them
    • Focus on delivering service at the first visit, not completing paperwork
  • **Patient Engagement**
    • Second appointment within in seven days, with the same person
    • Persons Centered Assessment and Planning
      • What’s worked for me in the past?
      • How and who has been helpful in the past?
      • What’s new out there that might help me this time?
Patient Engagement – Life Style Change

- Core principle of recovery, “I” have to change “my” life style choices/behaviors
- What works in Health Behavior Change?
What Works – Health Promotion
Wellness

**Most likely to be effective:**

- Longer duration - 6 months
- Manualized combined education and activity-based approach
- Both nutrition and physical exercise
- Evidence-based (proven effective by RCTs)
. Less likely to be successful:

- Briefer duration interventions
- General wellness or health promotion education-only programs
- Non-intensive, unstructured, or non-manualized interventions
- Programs limited to nutrition only or exercise only (as opposed to combined nutrition and exercise).
Selecting a Health Promotion Program for Implementation:

- Evidence-based: supported by rigorous outcome research (preferably RCTs)
- Manualized with training and supervision
- Feasible: Demonstrated track record of successful implementation and sustainability
- Resources at: [www.integration.samsah.gov](http://www.integration.samsah.gov)
  Search for Steve Bartels
Multi-disciplinary (Integrated) Teams
The New Team

- The Consumer
- Consulting Psychiatrist
- Primary Care Provider
- Behavioral Health Clinician
- Care Manager
Role of Psychiatrists/Providers

PRIMARY CARE PROVIDERS
• Shared responsibility for consumer care
• Prescribing for BH as comfort develops
• One treatment plan
• One record for documenting

PSYCHIATRIST
- Consulting role
  - Curbside consults
  - Case conferences
  - Available all hours clinic is open
  - Some (fewer) evaluations
- Training
  - Support Primary Care Physician in prescribing behavioral health meds
  - Combined Grand Rounds/Training
Role of BH Clinician

- Short term solution focused therapy
- 1-3 Sessions
- Always available
- Consultation to the primary care provider
- Dually trained in MH and SA EBP’s AND key physical health diagnoses
Case to Care Management

Case Management
- Person based
- BH Only
- Referral based

Care Management
- Population based with personal attention
- BH + PC
- Active/engaging/on-site
Resource for Team Composition and Skills: AIMS Center at University of Washington
Real Time Communication – Clinical Information Systems

- Electronic Medical Records are a must!
- Single, web-based integrated record, with consumer access
- Health Information Exchanges
- Confidentiality is not an issue!
Models of/for Integration
## Levels of Integration

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

Behavioral health, primary care and other healthcare providers work:

<table>
<thead>
<tr>
<th>In separate facilities, where they:</th>
<th>In separate facilities, where they:</th>
<th>In same facility not necessarily same offices, where they:</th>
<th>In same space within the same facility, where they:</th>
<th>In same space within the same facility (some shared space), where they:</th>
<th>In same space within the same facility, sharing all practice space, where they:</th>
</tr>
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</table>
### What Level for Success?

<table>
<thead>
<tr>
<th>Have separate systems</th>
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<th>Have separate systems</th>
<th>Share some systems, like scheduling or medical records</th>
<th>Actively seek system solutions together or develop work-arounds</th>
<th>Have resolved most or all system issues, functioning as one integrated system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate, driven by specific patient issues</td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
<td>Communicate in person as needed</td>
<td>Communicate frequently in person</td>
<td>Communicate consistently at the system, team and individual levels</td>
</tr>
<tr>
<td>Communicate, driven by provider need</td>
<td>Communicate, driven by specific patient issues</td>
<td>Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
<td>Collaborate, driven by desire to be a member of the care team</td>
<td>Collaborate, driven by shared concept of team care</td>
</tr>
<tr>
<td>May never meet in person</td>
<td>May meet as part of larger community</td>
<td>Meet occasionally to discuss cases due to close proximity</td>
<td>Have regular face-to-face interactions about some patients</td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
<td>Have formal and informal meetings to support integrated model of care</td>
</tr>
<tr>
<td>Have limited understanding of each other’s roles</td>
<td>Appreciate each other’s roles as resources</td>
<td>Feel part of a larger yet ill-defined team</td>
<td>Have a basic understanding of roles and culture</td>
<td>Have an in-depth understanding of roles and culture</td>
<td>Have roles and cultures that blur or blend</td>
</tr>
<tr>
<td>Contact: <a href="mailto:Communications@TheNationalCouncil.org">Communications@TheNationalCouncil.org</a></td>
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Resource for Framework:

[www.integration.samhsa.gov](www.integration.samhsa.gov) – search Bern Heath or strategic framework
Implementing the Framework
The Four Quadrant Clinical Integration Model

Quadrant II
BH ↑ PH ↓
- BH Case Manager with 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 with 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 SPMI 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

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.
Quadrant I

- Quadrant I: Low BH/Low PH
  - PCP (with standard screening tools and BH practice guidelines)
  - PCP- Based BH

- Interventions
  - Screening for BH Issues (Annually)
  - Age Specific Prevention Activities
  - Psychiatric Consultation

- Financing
  - Primary Care Visits
  - SBIRT Codes for Substance Abuse
Quadrant II

- **Quadrant II – High BH/Low PH**
  - ✓ BH Case Manager w/responsibility for coordination w/PCP
  - ✓ PCP with tools
  - ✓ Specialty BH
  - ✓ Residential BH
  - ✓ Crisis/ER
  - ✓ Behavioral Health IP
  - ✓ Other Community Supports

- **BH Interventions in Primary Care**
  - ✓ IMPACT Model for Depression
  - ✓ MacArthur Foundation Model
  - ✓ Behavioral Health Consultation Model
  - ✓ Case Manager in PC
  - ✓ Psychiatric Consultation

- **PC Interventions CMH**
  - ✓ NASMHPD Measures
  - ✓ Wellness Programs
  - ✓ Nurse Practitioner, Physician’s Assistant, Physician in BH

- **Financing**
  - ✓ Disease Management Pilot in Michigan
  - ✓ CMH Capitation
  - ✓ Two BH visits a month in primary care
Quadrant III

- Quadrant III – Low BH/High PH
  - PCP with screening tools
  - Care/Disease Management
  - Specialty Med/Surg
  - PCP based- BH
  - ER

- Interventions
  - BH Ancillary to Medical Diagnosis
  - Group Disease Management
  - Psychiatric Consultation In PC
  - MSW in Primary Care
  - BH Registries in PC (Depression, Bipolar)

- Financing
  - 96000 Series of Health and Behavioral Assessment Codes
  - Two BH Visits a month are billable
Quadrant IV

- Quadrant IV- High BH/High PH
  - PCP with screening tools
  - BH Case Manager with Coordination with Care Management and Disease Management
  - Specialty BH/PH

- Interventions in Primary Care
  - Psychiatric Consultation
  - MSW in Primary Care
  - Case Management
  - Care Coordination

- Interventions in BH
  - Registries for Major PC Issues (Diabetes, COPD, Cardiac Care)
  - NASMPD Disease Measures
  - NP, PA or Physician in BH

- Financing
  - BH Capitation
  - Primary Care Visits
Models/Strategies – Bi-Directional Integration

Behavioral Health – Disease Specific
- IMPACT
- RWJ
- MacArthur Foundation
- Diamond Project
- Hogg Foundation for Mental Health
- Primary Behavioral Healthcare Integration Grantees

Behavioral Health - Systemic Approaches
- Cherokee Health System
- Washtenaw Community Health Organization
- American Association of Pediatrics - Toolkit
- Collaborative Health Care Association
- Health Navigator Training

Physical Health
- TEAMcare
- Diabetes (American Diabetes Assoc)
- Heart Disease
- Integrated Behavioral Health Project – California – FQHCs Integration
- Maine Health Access Foundation – FQHC/CMHC Partnerships
- Virginia Healthcare Foundation – Pharmacy Management
- PCARE – Care Management

Consumer Involvement
- HARP – Stanford
- Health and Wellness Screening – New Jersey (Peggy Swarbrick)
- Peer Support (Larry Fricks)
• **Contact Information**

  ✓ [kathyr@thenationalcouncil.org](mailto:kathyr@thenationalcouncil.org)
  ✓ [www.integration.samhsa.gov](http://www.integration.samhsa.gov)