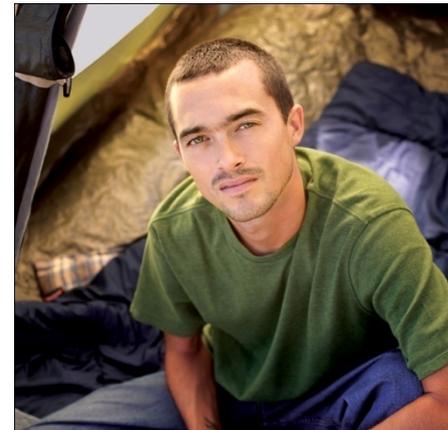


Bi-Directional Integration: What Degree of Integration is Needed for Success – Linking Indiana Integration Principles to National Models



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

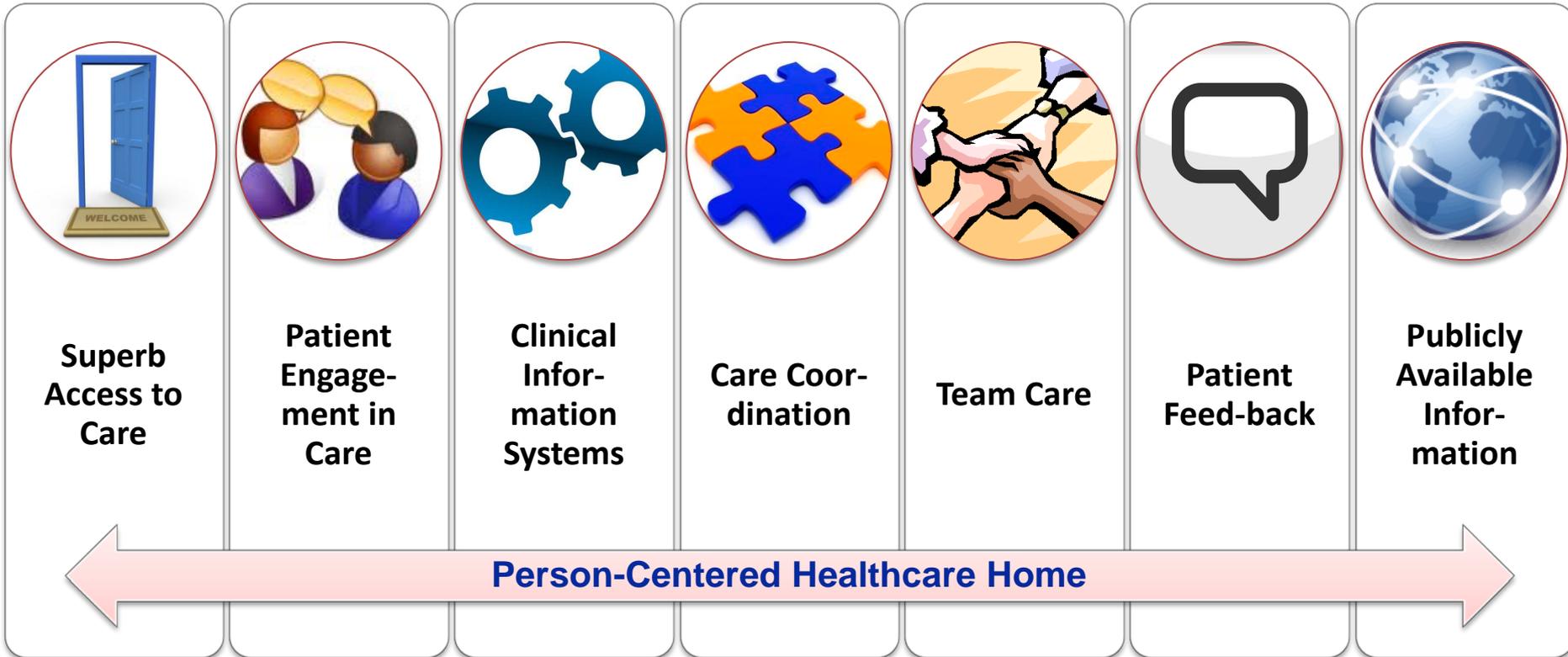
- **A holistic approach to serving humans when it comes to health care and quality of life that includes recovery principles**
 - ✓ Empowering individuals to improve their overall health status and quality of life
 - ✓ Emphasizing life style change that promotes high levels of personal resiliency
- **Holistic 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**

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

- **Use of Evidence Based Practices**
- **Continuous quality improvement and the use of data – Second webinar topic**

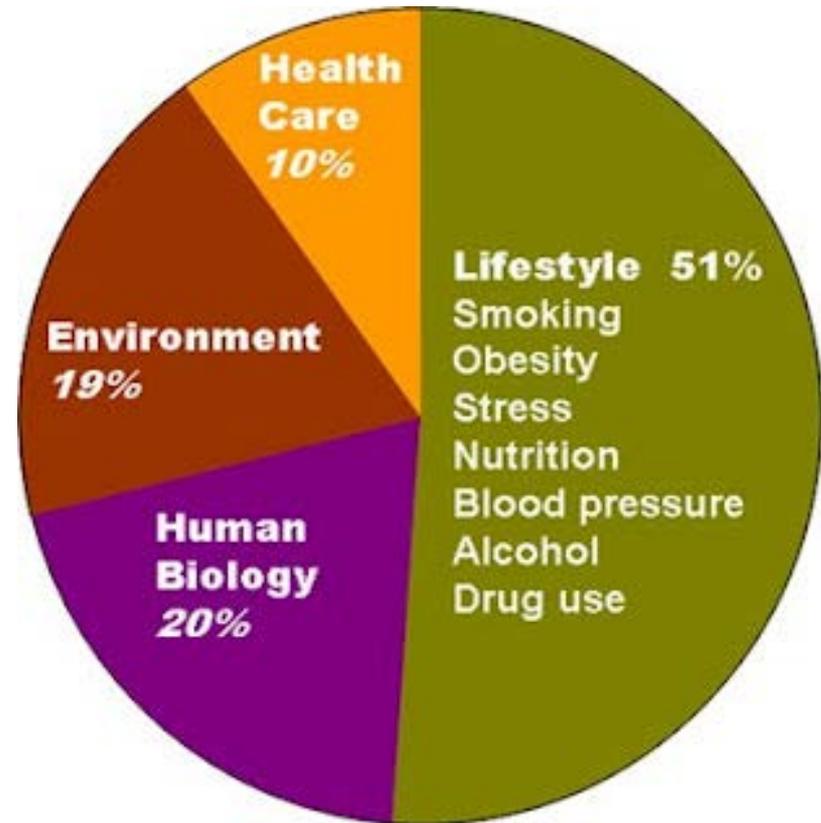
The Holistic Approach and Recovery Principles and the Health Home/Integration Structure

Defining the Healthcare Home



- **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?

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



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:

www.TheNationalCouncil.org

- **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
Search for Steve Bartels

Multi-disciplinary (Integrated) Teams

- **The Consumer**
- **Consulting Psychiatrist**
- **Primary Care Provider**
- **Behavioral Health Clinician**
- **Care Manager**

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

- **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 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

- **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

		Co-Located		Integrated	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1 <i>Minimal Collaboration</i>	Level 2 <i>Basic Collaboration at a Distance</i>	Level 3 <i>Basic Collaboration On-Site</i>	Level 4 <i>Close Collaboration On-Site with Some System Integration</i>	Level 5 <i>Close Collaboration Approaching an Integrated Practice</i>	Level 6 <i>Full Collaboration in a Transformed/ Merged Integrated Practice</i>
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:

What Level for Success?

<ul style="list-style-type: none"> • Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of larger community • Appreciate each other's roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly about shared patients, by phone or e-mail • Collaborate, driven by need for each other's services and more reliable referral <ul style="list-style-type: none"> • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> • Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together or develop work-a-rounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues, functioning as one integrated system • Communicate consistently at the system, team and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend
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Resource for Framework:

www.integration.samhsa.gov – search
Bern Heath or strategic framework

Implementing the Framework

The Four Quadrant Clinical Integration Model



*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: 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 – 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 – 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- 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
- ✓ www.integration.samhsa.gov