Integration 101: An Overview

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What is Integration?

- Healthcare is “putting the head back on the body” and looking at ways to care for the whole person (National Council, 2017)

- Systematic coordination of physical and behavioral healthcare (SAMHSA, 2017)

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Integrated Health: definition

- “A practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.
- This care may address mental health and substance abuse conditions, health behaviors (incl. their contribution to chronic medical illness), life stressors and crises, stress-related physical symptoms, and in-effective patterns of health care utilization”

Peek, C.J. (2013). https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Seeking BH Care in PC

- Most people seek help for BH problems in PC settings
- ½ of all care for common psychiatric disorders happens in PC settings
- Populations of color are more likely to seek or receive care in PC than in specialty BH settings
- Uninsured or underinsured
- Limited access to public MH services
- Cultural beliefs and attitudes
- Availability of MH services, especially in rural areas

Alexander, L. (2010). Bidirectional Integrated Care 101:What you need to know. Retrieved from https://www.integration.samhsa.gov/about-us/Understanding_Primary_and_Behavioral_Healthcare_Integration_2010-09-15_FINAL.pdf

BH Problems in PC

- Mild to moderate BH issues are common in PC settings
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, behavioral problems in children
    - **Prevention and early intervention opportunity**

- People with common medical disorders have high rates of BH issues
  - E.g., Diabetes, heart disease, & asthma **+** depression
    - **Worse outcomes & higher costs if both problems aren't addressed**

Alexander, L. (2010). Bidirectional Integrated Care 101:What you need to know. Retrieved from https://www.integration.samhsa.gov/about-us/Understanding_Primary_and_Behavioral_Healthcare_Integration_2010-09-15_FINAL.pdf

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Medical Issues in BH Settings

- People with serious mental illness (SMI) are dying 25 years earlier than the general population.

- 2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases.

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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*
Behavioral health, primary care and other healthcare staff 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.**

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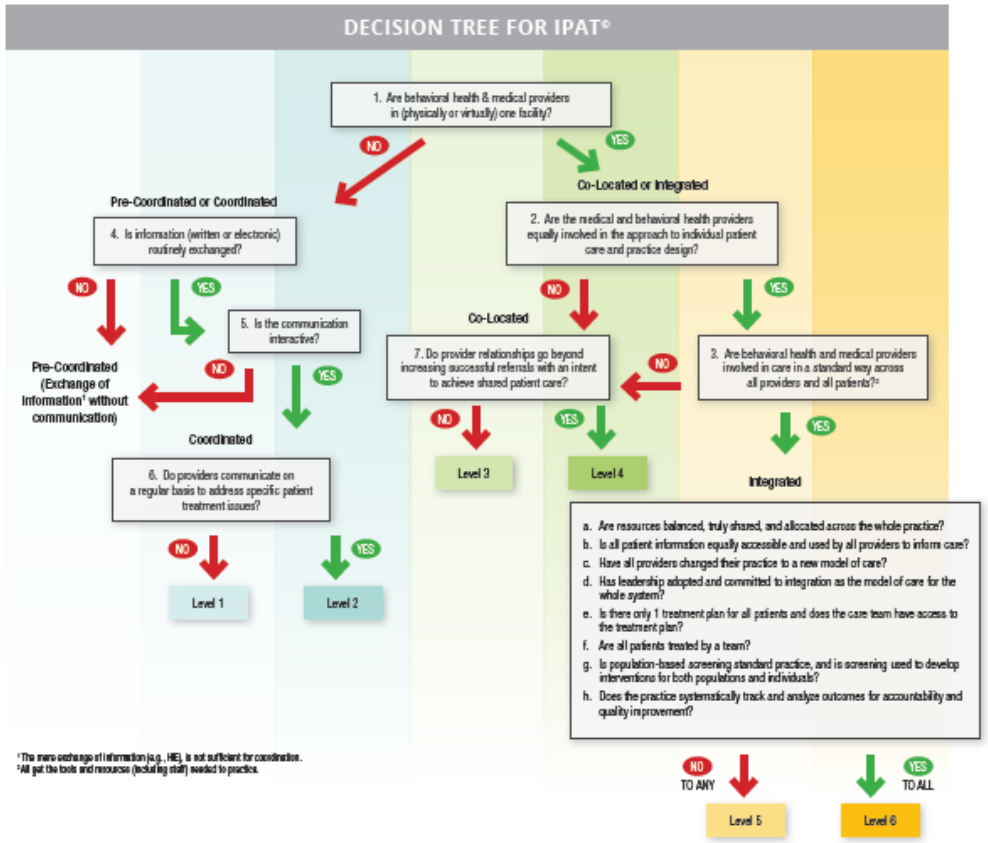

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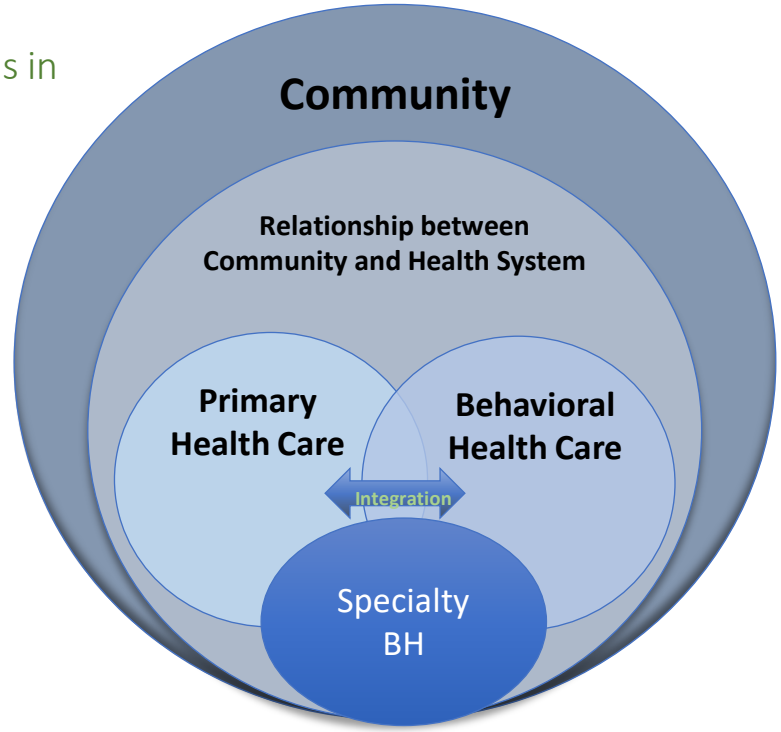
Integration happens in the context of the community…



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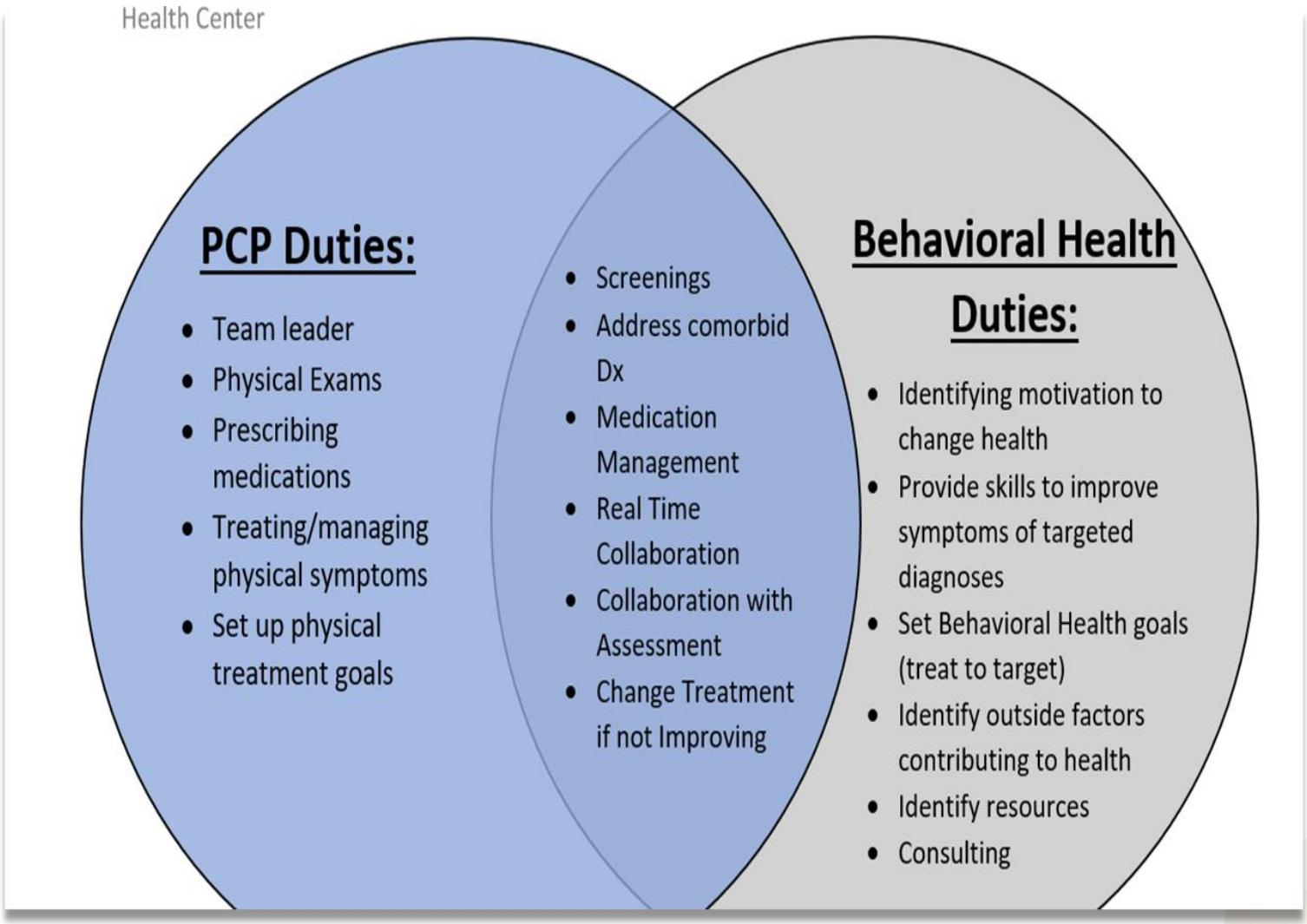
Behavioral Health Clinician/Coordinator (BHC) Services

- Direct Clinical Services
  - Brief, evidence-based interventions during pt. visits (Visits are 15-30 min); Group interventions
- Training/Impact on Team
  - Presentations at meetings (e.g., Motivational Interviewing, etc.)
  - Educational flyers; Development of shared treatment plans
- Supporting the system
  - BHC follows up (less follow-up for PCP); See pts while they wait for PCP; Allows PCP to move onto the next patient, collaborates with care coordinator
  - Tracking and follow-up


Health Center
PCP Duties:
Team leader
Physical Exams
Prescribing medications
Treating/managing physical symptoms
Set up physical treatment goals
Screenings
Address comorbid Dx
Medication Management
Real Time Collaboration
Collaboration with Assessment
Change Treatment if not Improving
Behavioral Health Duties:
Identifying motivation to change health
Provide skills to improve symptoms of targeted diagnoses
Set Behavioral Health goals (treat to target)
Identify outside factors contributing to health
Identify resources
Consulting

The New Milk

- For patients and you:
  - Chronic conditions
  - The Quadruple AIM
    - Improves Patient experience
    - Improved Clinician experience
    - Decreases Costs
    - Improves Quality

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Putting Integration Into Practice

The tools and tricks of the trade

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How do we get there from here?

Trauma Informed Care

Whole health & wellness integrated care practices

Recovery & Resilience framework/ practice

Family & Community Connections

Case management, Care coordination, care management & data driven care

Methods: MI, shared decision making, PST/BA, EBP Wellness

Components of Integration

Patient-centered Language

Team-based care

Team Meetings

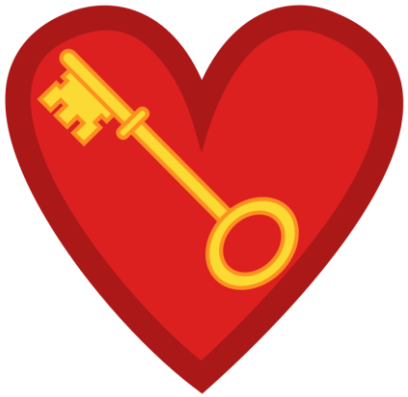
Daily Huddles

Warm Hand-offs and Warm Referrals

Electronic communication (EHR, Emails)

Use of Data

Screening



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Patient-centered Language

Get rid of the jargon!

Consider health literacy

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Team-based Care (TBC)

Fundamental definition

- At least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by patient – to accomplish shared goals and achieve coordinated, high quality care[1]
- Inter-disciplinary (e.g., BH professional, PCP, SW, nutritionist, peer support specialist)[1]
- Clear roles, mutual trust, effective communication, measurable processes and outcomes[2]

[1]Adapted from ACA definitions of team in Sections 2703 and 3502

[2]IOM White Paper: Mitchell, Wynia, Golden et al. (October 2012). Core Principles and Values of Effective Team-based Health Care.

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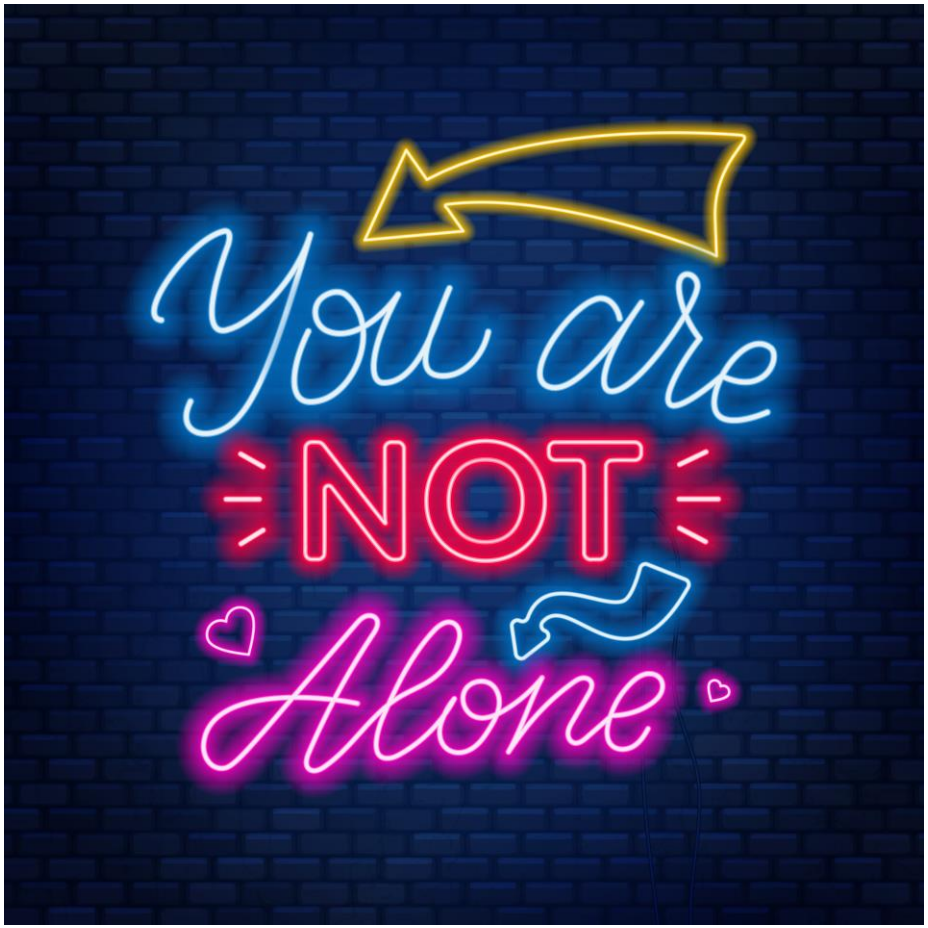

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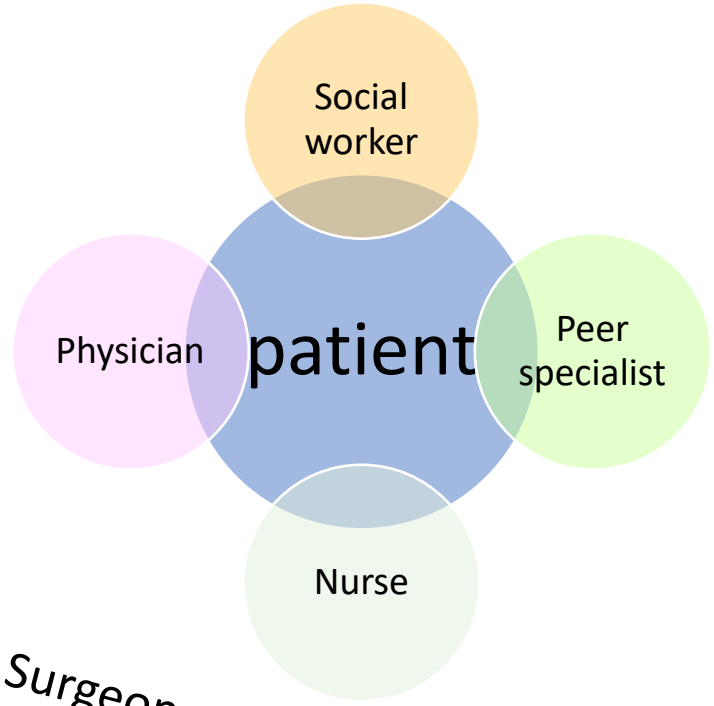


Medical assistant

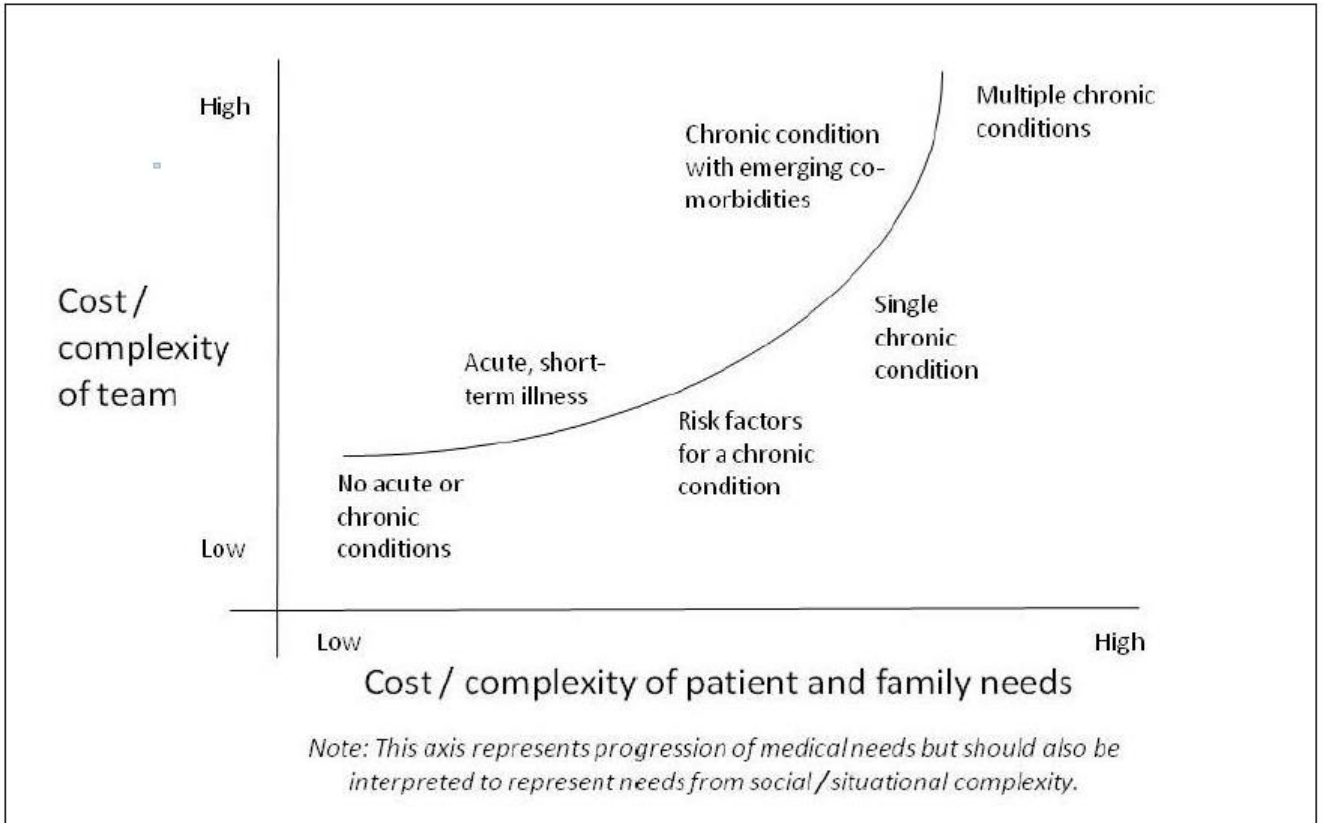
Project administrator

CEO

Surgeon

Community health worker

Receptionist



Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

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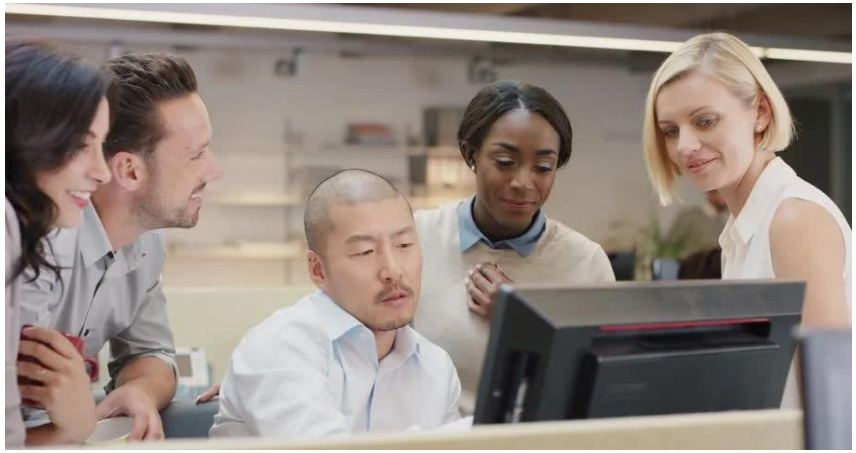
Team Meetings

Optimize time as a team

Have standing items

Incorporate team members in running the meeting



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Successful Huddles

Assess your practice: Care teams, staffing ratios, workflows and protocols/standing orders

Define realistic agenda for your huddles

Define roles for huddle participants

Address scheduling issues: Huddle and pre-work

Train on huddle roles

Ongoing assessment, training and addressing of barriers

Ghorob, A. & Bromer, S. (2013). Pre-Clinic Huddles: Supporting Effective Care Teams in the Patient Centered Medical Home.

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Define Realistic Huddle Agenda

Manage schedule

- Same-day availability
- Double books/frequent no-show/complex patients
- Provider/staff time

Manage patient issues

- Incomplete labs/referrals
- Procedures/labs due/chronic care alerts
- Different team member perspectives on patients

Manage care team communication issues

Check-in on CQI/PDSA cycles

Ghorob, A. & Bromer, S. (2013). Pre-Clinic Huddles: Supporting Effective Care Teams in the Patient Centered Medical Home.

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What is a Warm Hand-off

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Presenting Warm Hand-offs

When presenting to a patient, it is helpful to use terms like:	To reduce fear/stigma, avoid terms like
• Co-worker • Colleague • Someone who is an expert / specializes in… • “I work with *name* who is part of our team. I’d like to introduce you to them before you go.”	• Therapist • Social worker

Warm Hand-Off Referrals By the Primary Care Provider To the Behavioralist. (n.d.). Retrieved 2016, from California Mental Health Services Authority

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Warm Hand-off Best Practices

Engagement and rapport

Reinforces team concept

Allows for immediate start of treatment

An effective method for connecting patient with a staff person

Establish what clinical criteria (screening tools/scores and clinical concerns) should trigger a warm hand-off

Occurs throughout the day and is a fluid process

A face-to-face brief introduction, ending with an appointment made

Little, V., & James, T. (2014, May 22). Collaborative Care Best Practices: Recruitment and Retention. Retrieved 2016, from AIMS Center: http://uwaims.org/nyscci/files/slides_recruitment-retention_2014-05-22.pdf

Warm Hand-off Best Practices

Have a back-up plan: A back-up “warm referral” process should be in place.

Accountability is essential. Practices need to define expectations and roles for all participating providers.

The patient should feel that the providers are on the same team. It should be emphasized to patients that they will continue to see their PCP and that their care team has been enhanced.

Close the loop after the hand-off

- Use of the EHR
- Case conferencing
- Confirmation of appointment attendance

Use of an Electronic Health Record

Collaborative Documentation

Shared Care Planning / Treatment Planning

Decision Support

Reporting / Dashboards

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Data

$$\psi(x) \to \psi(x) + \varepsilon\varphi(x) \quad \{\text{A VARIATION } \varphi(x) \text{ IS ADDED}$$

$$\frac{\partial}{\partial E}(\Delta x)^2(\Delta p)^2 = (\Delta p)^2\frac{\partial}{\partial E}(\Delta x)^2 + (\Delta x)^2\frac{\partial}{\partial E}(\Delta p)^2 = 0$$

$$(\Delta x)^2\left[\left(\frac{h}{4\pi}\right)^2\left(\frac{1}{\Delta x}\right)^4\frac{\partial}{\partial E}(\Delta x)^2 + \frac{\partial}{\partial E}(\Delta p)^2\right] = 0 \quad \{\text{UNCERTAINTIES } \Delta p, \Delta x \text{ REPLACED BY } p', x'$$

$$\frac{\partial}{\partial E}\left[-\left(\frac{h}{4\pi}\right)^2\left(\frac{1}{\Delta x}\right)^2 + (\Delta p)^2\right] = 0 \quad \{(\Delta x)^2 > 0, \text{ OTHERWISE } (\Delta p)^2 \to \infty$$

$$\frac{\partial}{\partial E}\left[-\left(\frac{h}{4\pi}\right)^2 \cdot 4\int\left(\frac{d\psi(x)}{dx}\right)^2 dx + 2m\int(E - V(x))\,\psi^2(x)\,dx\right] = 0 \quad \{\text{USING (5) \& (6)}$$

$$-\left(\frac{h}{2\pi}\right)^2\int\frac{d\psi(x)}{dx}\cdot\frac{d\varphi(x)}{dx}\,dx + 2m\int(E - V(x))\,\psi(x)\,\varphi(x)\,dx = 0 \quad \{\frac{\partial}{\partial E}\,\mathcal{L}\,\varepsilon = 0 \ (7)$$

$$\int\left[\left(\frac{h}{2\pi}\right)^2\frac{d^2\psi(x)}{dx^2} + 2m(E - V(x))\psi(x)\right]\varphi(x)\,dx = 0 \quad \{\text{INTEGRATION BY PARTS, } \varphi(x) = 0 \text{ AT BORDERS}$$

$$\boxed{\frac{d^2\psi(x)}{dx^2} + 2m\left(\frac{2\pi}{h}\right)^2(E - V(x))\,\psi(x) = 0} \quad \{(1) = 0 \text{ FOR ALL VARIATIONS } \varphi(x)$$

SCHRÖDINGER'S WAVE EQUATION

Screening Across Services

- Prevention in addition to intervention
  - Diabetes
  - Substance use
  - Anxiety
  - Hypertension
  - Depression
  - Suicide

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Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- Identification of behavioral problems (alcohol, other drug, tobacco, depression, anxiety) & level of risk
  - Low risk:
    - Raise awareness and motivate client to change
  - Moderate risk:
    - Provide brief treatment (cognitive behavioral, medications) with clients who acknowledge risks and are seeking help
  - High risk:
    - Refer those with more serious or complicated MH/SU conditions to specialty care
  - Used in primary care centers, hospital ERs, trauma centers, and other community settings

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Considerations for Integration Sustainability

- Dashboard development
- Staffing
- Productivity/Volume
- Direct Revenue
- Indirect Revenue
- Coding
- Contracting
- Credentialing
- Optimization
- Back end-denials

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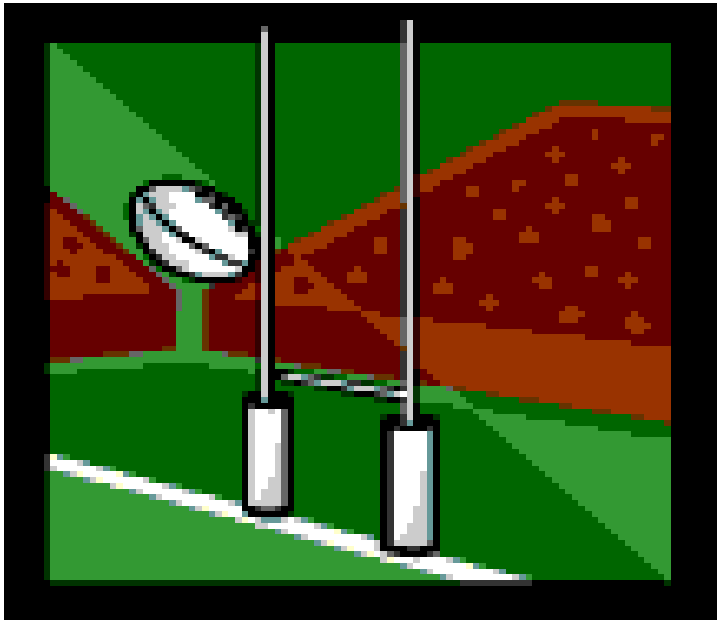
The Goal

- Operate fiscally sustainable clinics that demonstrate the efficient conversion of resources (employee time and effort) into effective patient-centered care



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- **Integration is** a process that occurs over time in the *entire* organization.

- **More than** having a good referral partner, care capacity, or a co-located site.

- **More than** a particular tool (e.g., PHQ 9), diagnostic combination (e.g., depression and diabetes), process (e.g., SBIRT), or evidence-based program (e.g., IMPACT).

- **Never ending!** Always new populations, partners, challenges, opportunities.

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Thank you!

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