



SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Defining Integrated Care

SAMHSA-HRSA Center for Integrated Health Solutions



- Expand integrated care as a national standard of practice
- Create and operate world-class technical assistance
- Ensure the success of SAMHSA & HRSA funded programs
- Disseminate practical tools, resources, and lessons learned

Integration Terms

Some Integrated Health Term Sources:

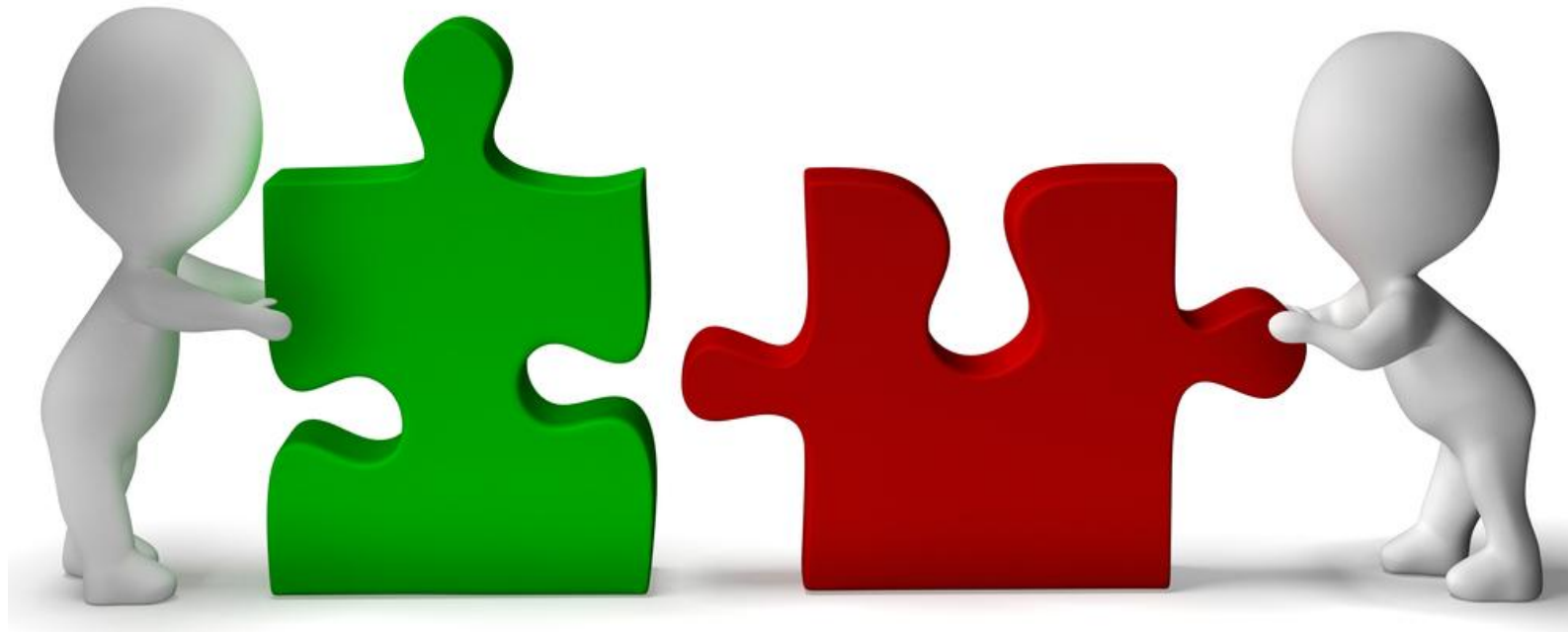
Research Literature- "Collaborative Care"

Policy- "Health Home"

Accrediting Bodies- "Patient Centered Medical Home"

Provider Agencies- "Pt. Centered Healthcare Home"

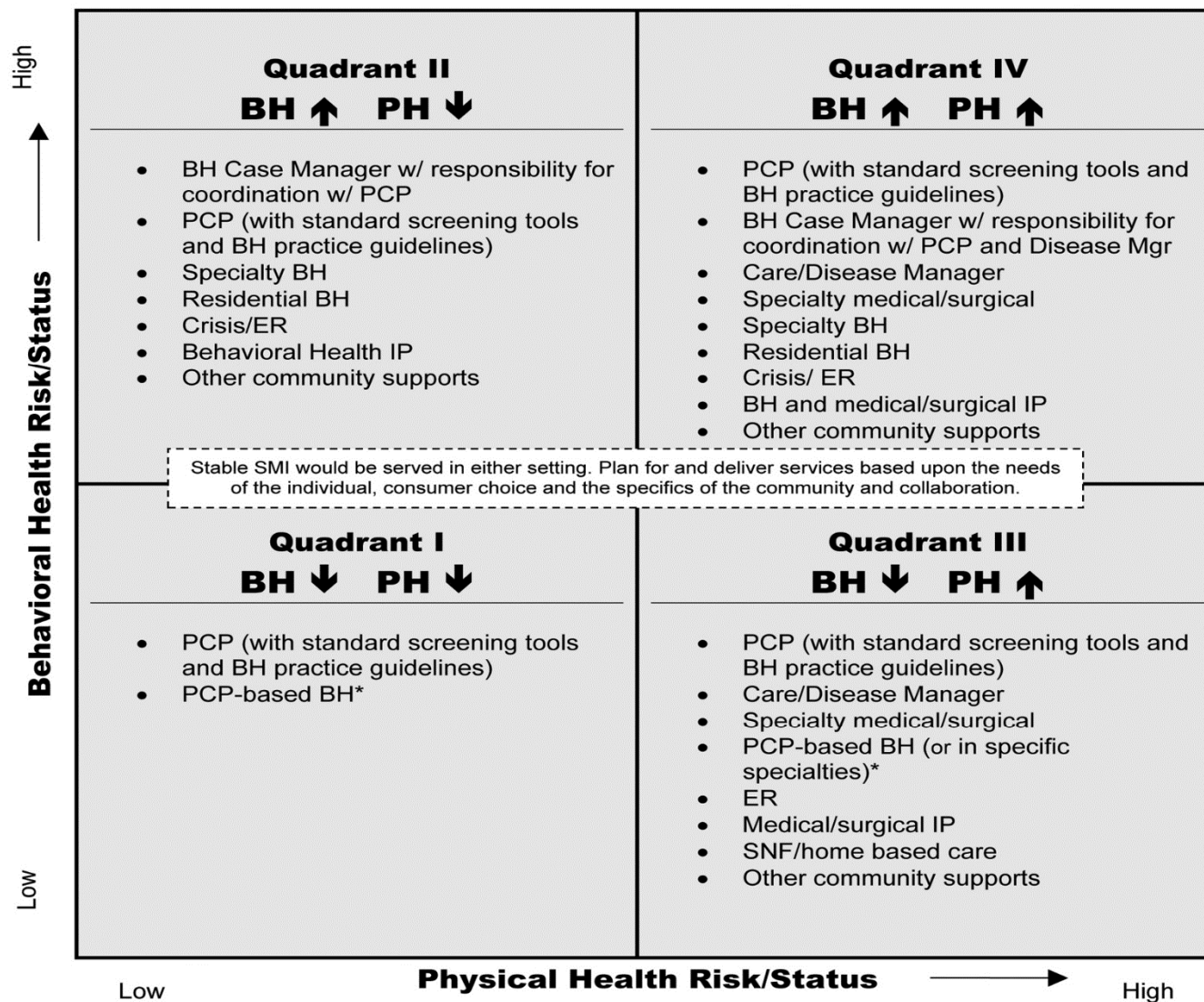
The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.*



LEVELS OF COMPLEXITY OF PATIENT'S MENTAL HEALTH NEEDS

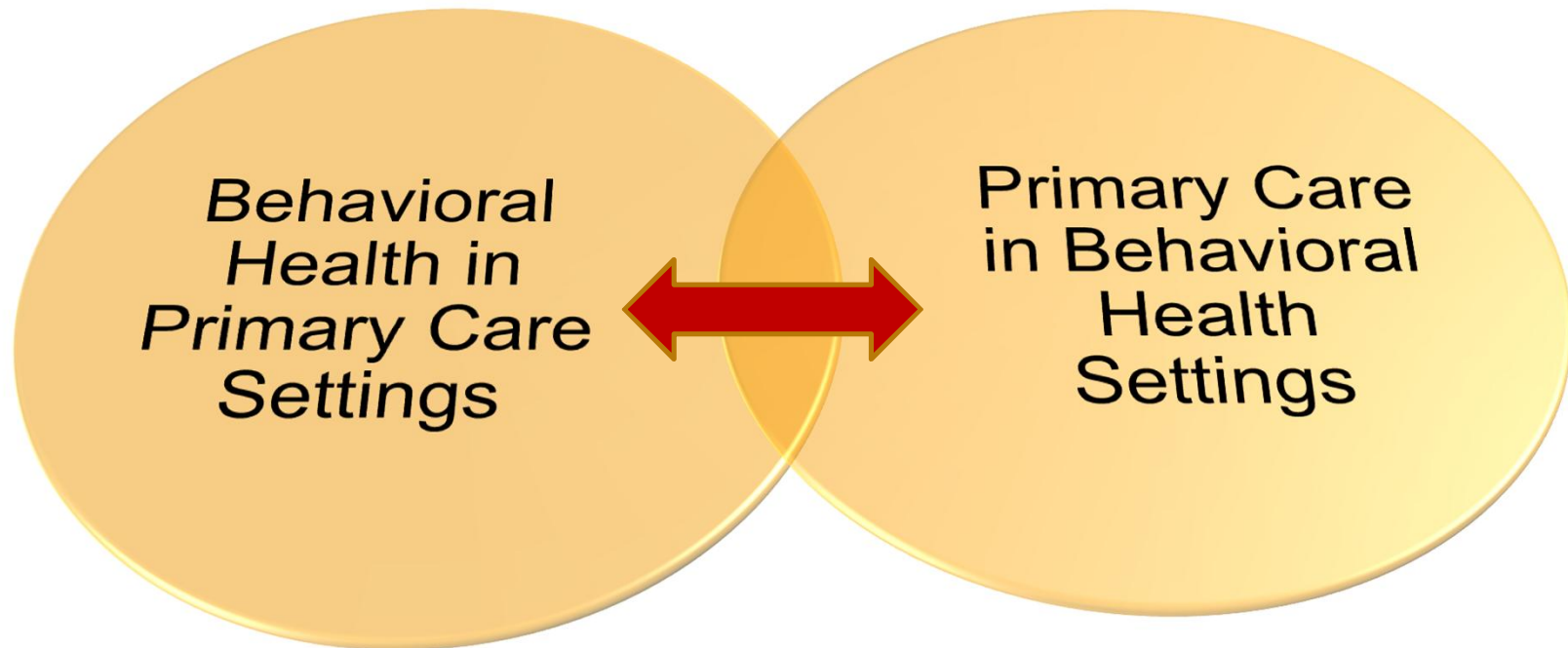
- ❖ Prevention Services and Screening
- ❖ Early Intervention and Routine Care Provision
- ❖ Specialty Consultation, Treatment & Coordination
- ❖ Intensive Mental Health Services for Complex Clinical Problems

Four Quadrant Model

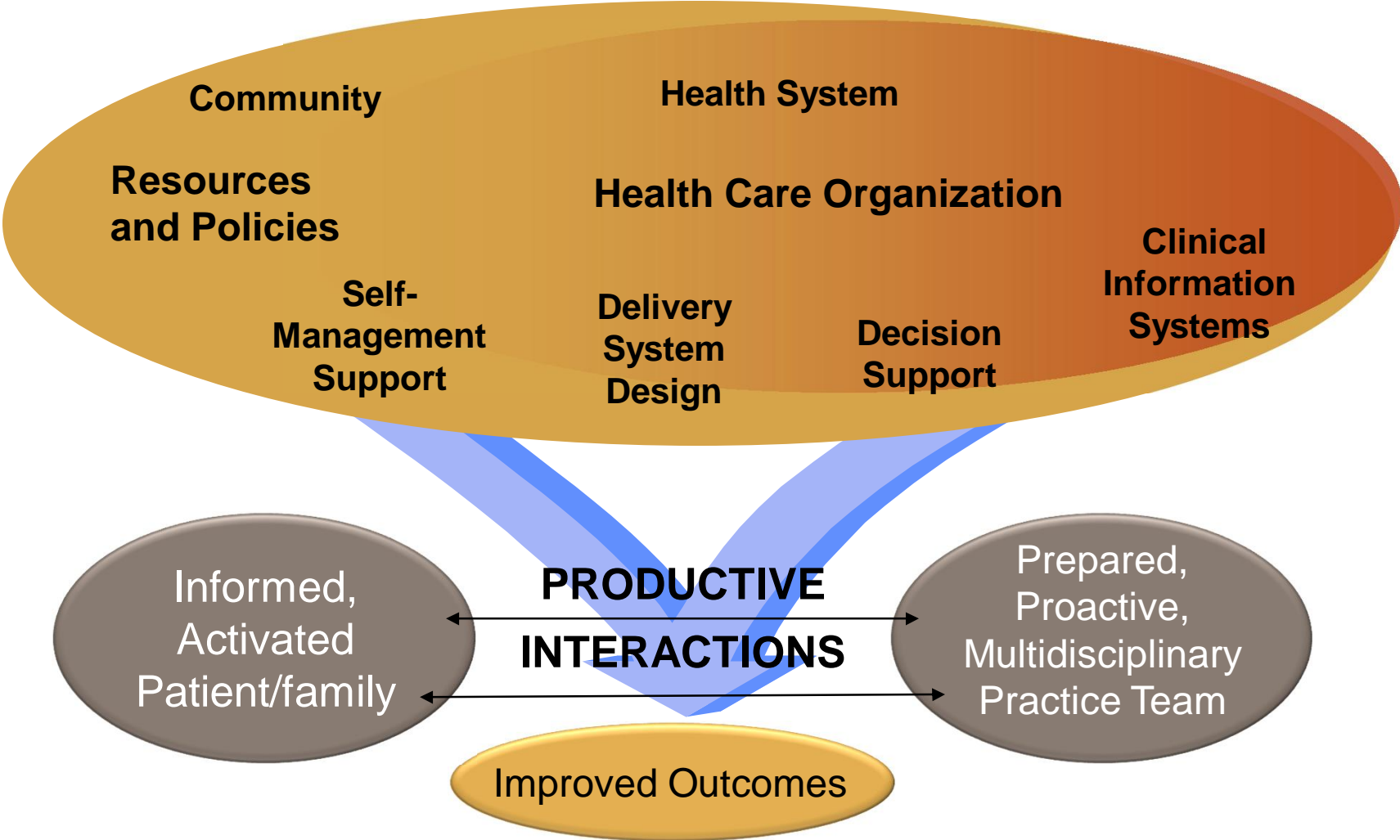


*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

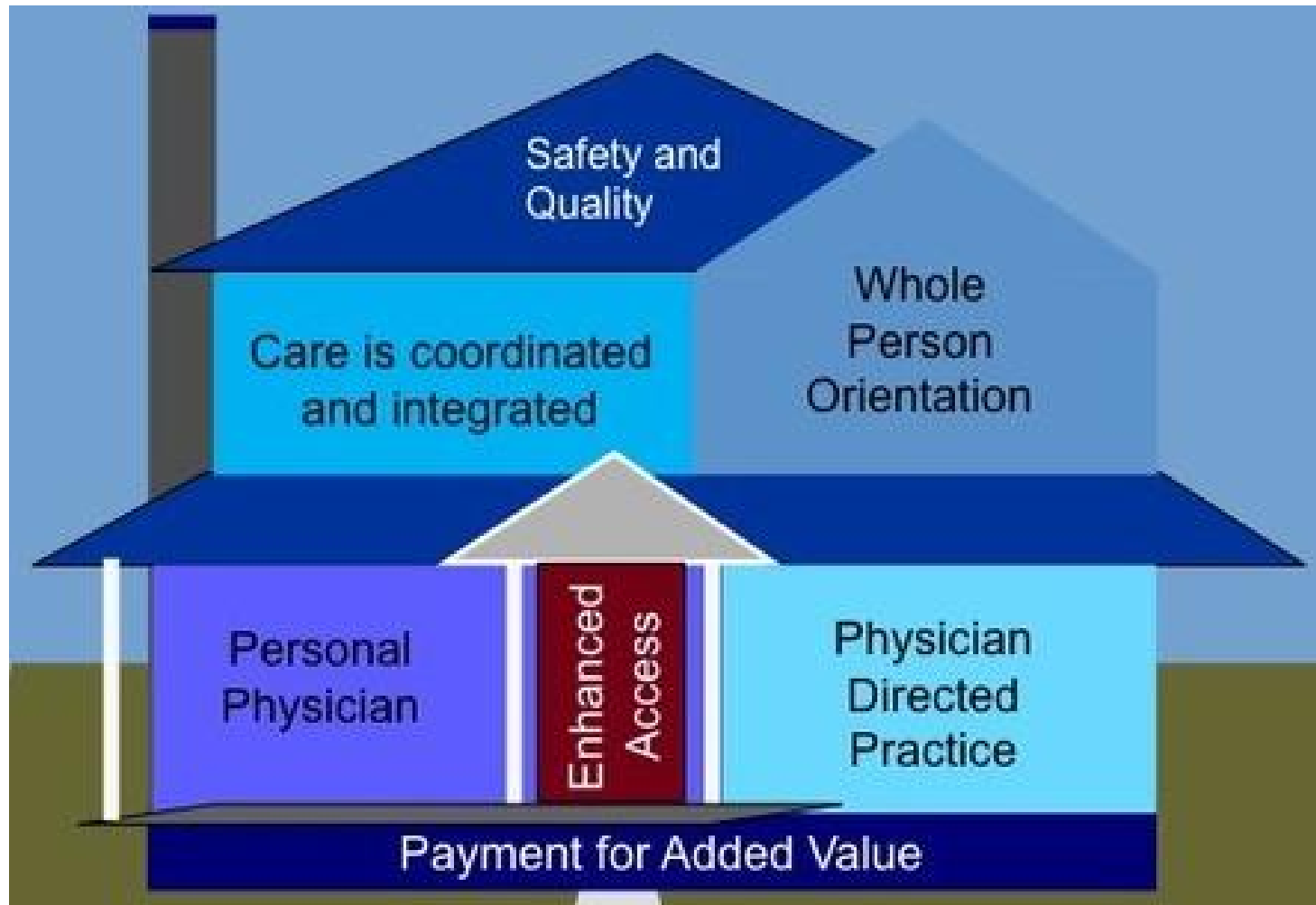
Bidirectional Integration



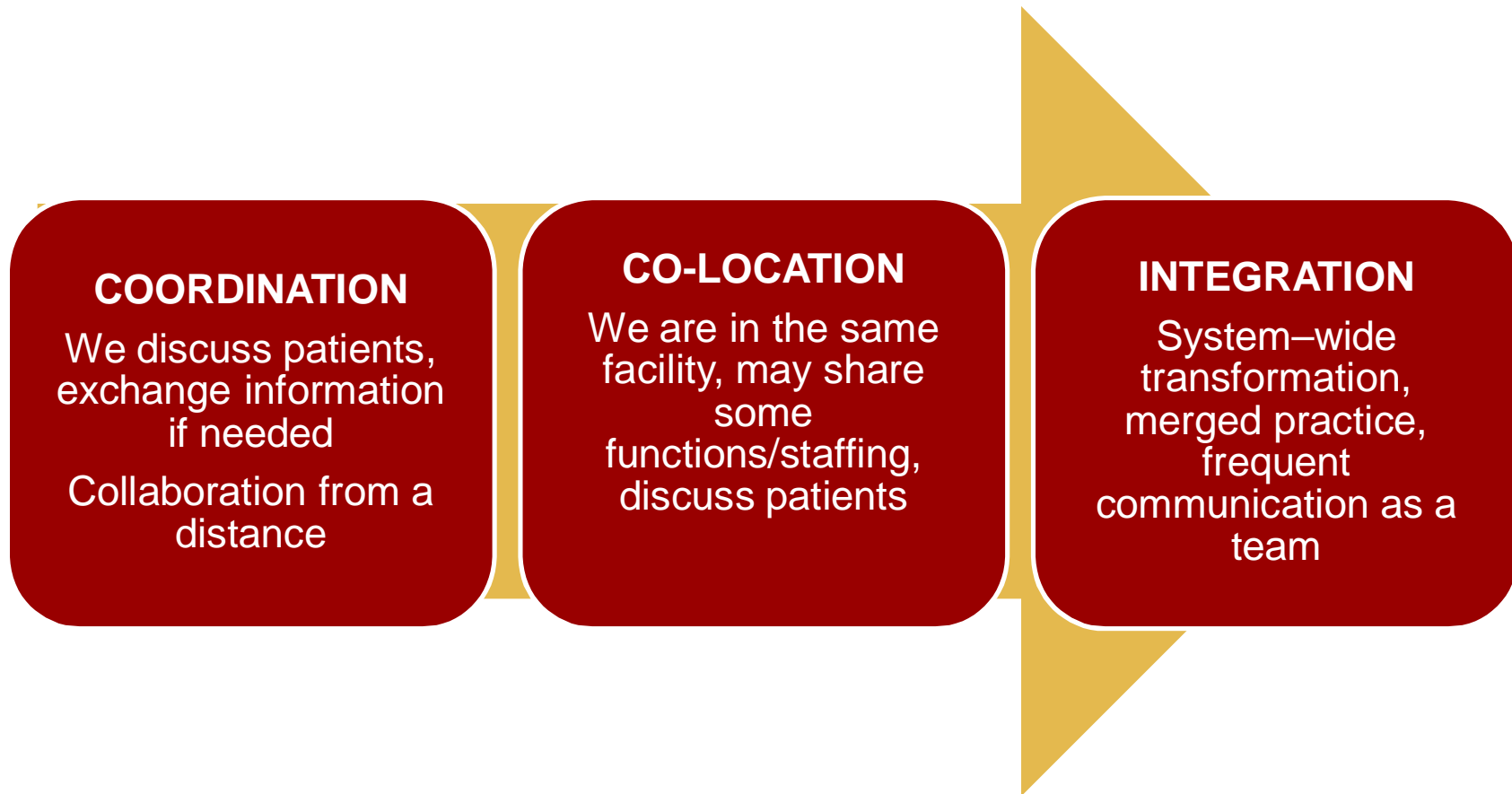
The Wagner Chronic Care Model



Patient Centered Medical Homes



Standard Framework of Integration



Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

6 Levels of Collaboration/Integration

- **Coordinated Care - Key Element is Communication**
 - Level I - Minimal collaboration
 - Level II – Basic collaboration at a distance

- **Co-Located Care - Key Element is Physical Proximity**
 - Level III - Basic collaboration on site
 - Level IV - Close collaboration on site with some system integration

- **Integrated Care - Key Element is Practice Change**
 - Level V - Close collaboration approaching an integrated practice
 - Level VI - Full collaboration in a transformed merged integrated practice

Differences by Level of Integration

Level	Proximity	Systems	Communicate	Meet
I	Separate facilities	Separate	Rarely as provider needs	Maybe never
II	Separate facilities	Separate	Periodically as patient needs	As larger community
III	Same facility Separate space	Separate	Regularly by phone or email	Occasionally to discuss cases
IV	Same facility Share space	Some shared	Regularly in person as needed	Regular on some patients
V	Some shared space	Partially integrated	Frequently in person	Regular team meetings
VI	Share all space	Fully integrated	Consistently as individuals & team	Team meets on systems & patients





Recurrent Themes on the Path to Integration

Building Relationships

Communication

Understanding the Model

Physical Structure Modifications

Hiring and Retaining the Right Staff

Revise state regulations to support the BHC Model

Billing Codes need revision to support Integration

The Organizational Components Impacted by Adoption of IH Models

- ❖ Staffing
- ❖ Building Design
- ❖ Partnerships/Contracting
- ❖ Financing
- ❖ Clinical Practice
- ❖ Health Information Technology
- ❖ Quality Assurance & Improvement
- ❖ Marketing/Customer Service

From the Field – Lessons Learned

- A Vision and Culture of Health
- Population Health Management
- A Sustainable Business Model
- Activating Self-Management
- A Prepared Workforce

A Vision and Culture of Health

- ❖ In it for the long haul - Top sustaining grantees changed their organization rather than operating a standalone program.
- ❖ Agility – Change adept, operate entrepreneurially, adapting quickly to reach desired outcomes.
- ❖ Accountability - Clear about their goals and metrics, managed partners and used data to identify opportunities to improve outcomes and make adjustments as needed.
- ❖ Organizational Culture – Shared value and language that facilitated internal and external communication
- ❖ Policies & Procedures that reflect and reinforce a shared vision

Population Health Management

- ❖ Population-Based Care: Caring for the whole population serving by the organization, not just the individuals actively seeking primary care.
- ❖ Data-Driven Care: Utilize data and analytics in order to make informed decisions to serve those in the clinic population who most need care.
 - ❖ Health registries and population management strategies
 - ❖ Client-level data to support CQI efforts
- ❖ EMR/EHR Systems. Behavioral health providers can and should participate in “Meaningful Use” and the exchange of patient information.

Activating Self-Management

- Creating health goals that address an individual's desire to make necessary changes to improve their health
- Make use of the best available evidence to guide the delivery of care and wellness interventions
- Base wellness activities on what clients want
- Involvement of peers in wellness and care coordination activities to support recruitment and engagement of clients
- Take advantage of all opportunities to teach how to live healthier lifestyles within existing programs
- Maintaining long-term engagement of clients in primary care services to impact those health conditions that require longer-term intervention (i.e., weight loss and tobacco cessation)

Sustainable Business Model

- ❖ Planning for sustainability in the first year of the grant
- ❖ Improve payer mix to support primary care billing
- ❖ PC partners need meaningful participation- shared responsibility for administration, clinical facilities, operations, record keeping, etc.
- ❖ Identify funding sources for non-billable services / embed wellness services in existing billable services
- ❖ Calculating patient volume is key
- ❖ Understanding the cost-benefits associated with integrated care
- ❖ Align integration efforts with Medicaid Health Homes, contracting opportunities with local hospitals, etc.

A Prepared Workforce

- ❖ Well equipped care coordinators that have the expanded skills they need to help the people they serve navigate the new healthcare marketplace and manage their whole health needs.
- ❖ Role of nurse care managers as a "bridge" across systems to successful integrated team functioning and integrated treatment planning
- ❖ Implementing mechanisms to support integrated team functioning, including hallway consults and daily/weekly team huddles
- ❖ Culture change (PC and BH staff) - reinterpreting one's clinical role in the context an integrated care environment
- ❖ Role of peer wellness coaches in supporting health and wellness interventions, and ongoing recruitment and engagement of clients being served

Assessing Your Readiness

State-Based Resource

- [MassHealth Regulations](#) that Hinder the Integration of Behavioral Health and Primary Healthcare (pg 141) & [BCBS Report](#)
- [CMS Medicaid Health Homes Core Measure Set](#)

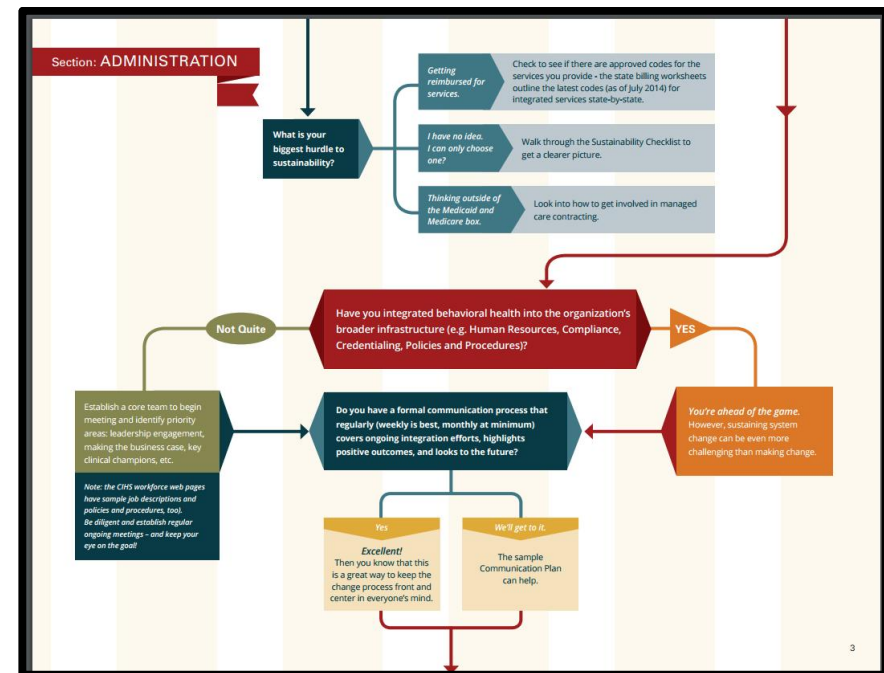
Provider Readiness

- [Assessment Tools for Organizations Integrating Primary Care and Behavioral Health](#)
 - Organizational Assessment Toolkit for PC/BH Integration (OATI)
 - Integrated Practice Assessment Tool (IPAT)
 - Behavioral Health Integration Capacity Assessment (BHICA)
- [AHRQ Self-Assessment Checklist for Integrating Behavioral Health and Ambulatory Care](#)

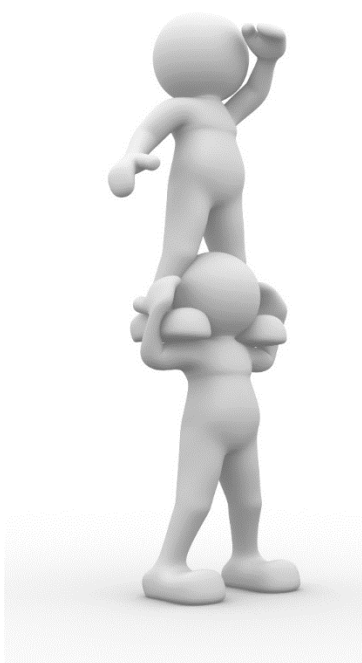
Quick Start Guide to Behavioral Health Integration

Questions to consider when integrating behavioral health care

- Administration
- Workforce
- Clinical Practice



The Business Case for the Integration of Behavioral Health and Primary Care



- ✓ Cost of Screening (S)
- ✓ Cost of Intervention Services (I)
- ✓ Transition Costs (T) must be less than or equal to Screening Reimbursement (X)
- ✓ Productivity Gains (P)
- ✓ Reimbursement for Treatment (R)

Measuring Integrated Care

Structure

Process

Outcome

Patient Experience

Facility Measures (Meaningful Use, PCMH)

Facility and Patient Measures (Readmission)

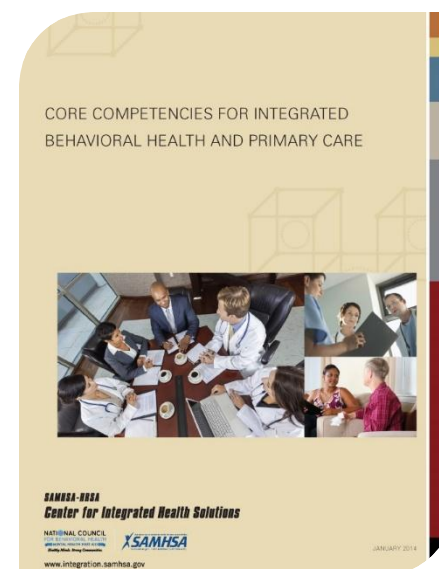
Patient Measures (value-based modifier)



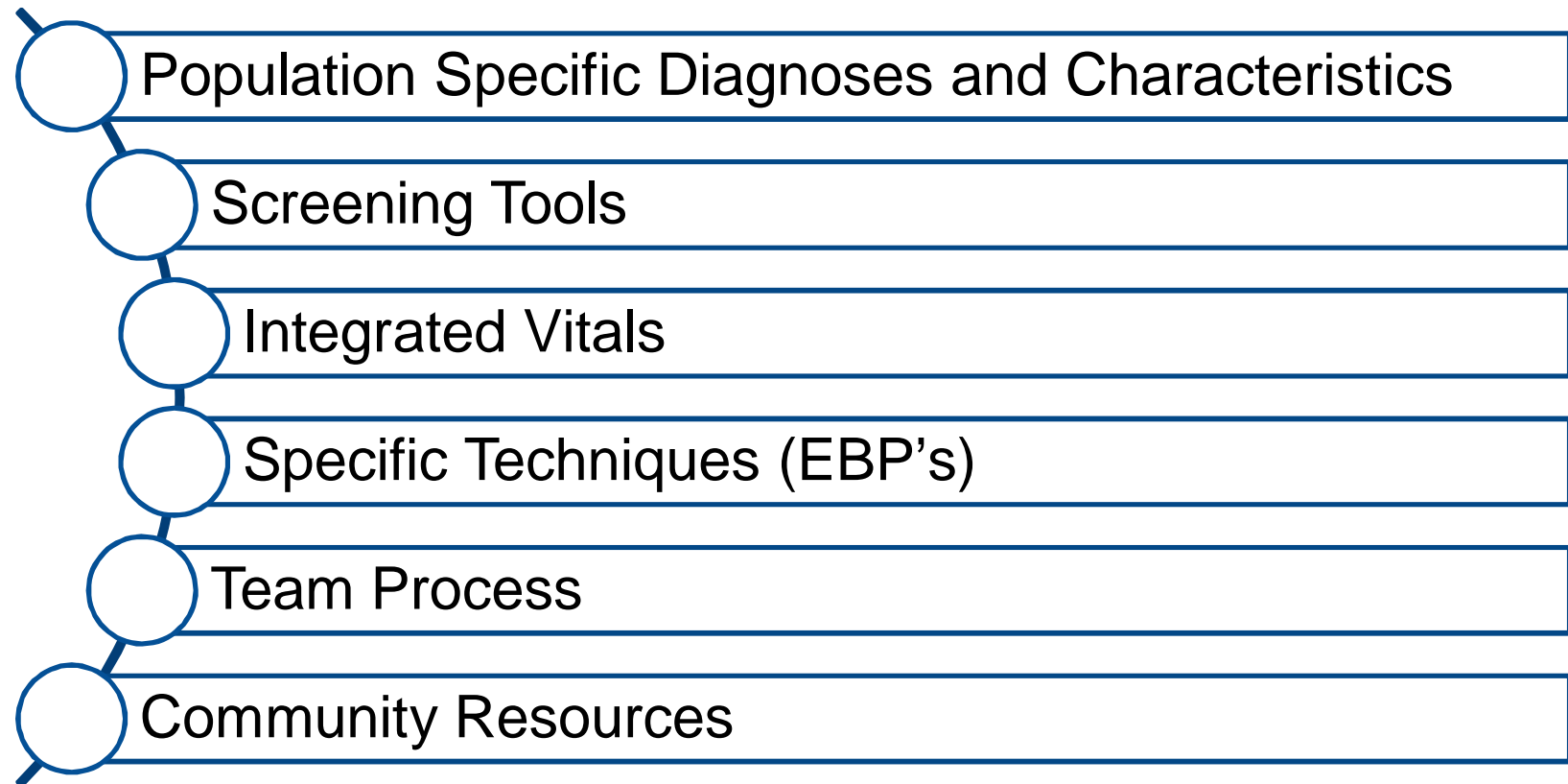
Core Competencies for Integrated Behavioral Health and Primary Care

A resource for primary and behavioral health care organizations as they shape job descriptions, orientation programs, supervision, and performance reviews for workers delivering integrated care.

- ✓ Interpersonal Communication
- ✓ Collaboration & Teamwork
- ✓ Screening & Assessment
- ✓ Care Planning & Care Coordination
- ✓ Intervention
- ✓ Cultural Competence & Adaptation
- ✓ Systems Oriented Practice
- ✓ Practice- Based Learning & Quality Improvement
- ✓ Informatics



Cross-Training is Essential



Tackling Culture Change

Questions about:

- Bandwidth (time)
- Strength of Evidence (Impact)
- Relative advantage (how much better)
- Relevance (whose job is it anyway)
- Cost (how much trouble is it)



Mark McGovern, CTN Science Series
Consolidated Framework for Implementation Research

*“It is great having my two providers in the same building because **they talk with each other at the time of the problem** rather than me having to wait until I see my provider for psych meds and/or my therapist.”*

– Jackie, Pathways Community Behavioral Healthcare, Clinton, MO

CIHS Tools and Resources

Visit www.integration.samhsa.gov or
e-mail integration@thenationalcouncil.org

The screenshot shows the homepage of the SAMHSA-HRSA Center for Integrated Health Solutions. At the top, there is a search bar with the text "Making Integrated Care Work" and the phone number "202.684.7457". Below the search bar is the organization's name, "SAMHSA-HRSA Center for Integrated Health Solutions", and a link to the "eSolutions newsletter". A navigation menu includes "About Us", "Integrated Care Models", "Workforce", "Financing", "Clinical Practice", "Operations & Administration", and "Health & Wellness". Social media links for Facebook, Twitter, and Listserv are also present, along with "Ask a Question" and "Email" options.

The main content area features a large image of a group of healthcare professionals in a meeting. Below this image is a section titled "Core Competencies for Integrated Behavioral Health and Primary Care", which includes a sub-header "An essential foundation for preparing and further developing an integrated workforce." and a numbered list of five items.

Below the core competencies is a "CALENDAR OF EVENTS" section with two entries:

- FEB 26** Substance Use and Mental Disorders: Early Detection, Prevention, and Treatment
FEBRUARY 26-26, 2014
- FEB 27** Integrating Peer Support in Primary Care
FEBRUARY 27-27, 2014

The "ABOUT CIHS" section includes the title "SAMHSA-HRSA Center for Integrated Health Solutions" and a paragraph: "CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings." A "LEARN MORE" button is located below this text.

The "TOP RESOURCES" section features two resource cards:

- FEBRUARY 24, 2014**
Integrating Physical and Behavioral Health Care: Promising Medicaid Models
- FEBRUARY 21, 2014**
February Is American Heart Month!

Each resource card includes a small image and a brief description. The first card's description reads: "This issue brief examines five promising Medicaid approaches to integrate physical and behavioral healthcare." The second card's description reads: "Individuals with serious mental illness and substance use disorders have a significantly higher risk of heart disease."

integration.samhsa.gov