Best Practices in Integration: Where the Rubber Meets the Road

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Agenda

• Core components of integrated care to improve health outcomes
• Examples of different models of integration, examples of typical services that are provided and successfully billed in each model, and key elements of each
• The top strategies for providers to implement to prepare for integrated partnerships
• Integration models that work for MCOs- how do you monitor and hold them accountable?
Core Principles of Integration

#1: The behaviorists role is to identify, target treatment, triage and manage consumers with medical and/or behavioral health problems using a behavioral approach.

#2: The integrated care program is grounded in population-based care philosophy consistent with the primary care model.

#3: The healthcare services are based on and consistent with a primary-behavioral health model

#4: The behaviorist promotes a smooth interface between, medicine, psychiatry, specialty mental health and other behavioral health services.

Core Components of Effectiveness

• Gilbody (2009) –
  • Consulting Psychiatrist
  • Care Coordination
  • Primary Care Prescriber – One Prescriber
• PBHCl Grantee Program
  • Peer Support
  • Wellness that includes education, exercise and nutrition

What do we know works?

• Consulting psychiatrist
• One prescriber (with consultation) whenever possible
• Care coordination – whole health (Gilbody, 2009)
• Consumer engagement/peer involvement
• Wellness programming
• Addressing core physical health issues sequentially
• Data, Data, Data (CIHS – PBHCl Grantees)
NASMHPD – Integrated Health Measures

Health Indicators
1. Personal History of Diabetes, HTN, CV disease
2. Family History of Diabetes, HTN, CV disease
3. Weight/Height, Body Mass Index
4. Blood Pressure
   Current
5. Blood C=Glucose or HbA1c
6. Lipid Profile
7. Tobacco Use/History
8. Substance Abuse
9. Medication: History and
   Current
10. Social Supports

Process Indicators
1. Screen/Monitor Risk and Health Conditions in MH
2. Access to and utilization of Primary Care Services

Models of Integration
- Levels of Collaboration/Integration
- Evidence Based and Promising Practices
<table>
<thead>
<tr>
<th>Function</th>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a Distance</th>
<th>Basic Collaboration On-Site</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated/Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE</strong></td>
<td></td>
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<tr>
<td>Access</td>
<td>Two front doors; consumers go to separate sites and organizations for services</td>
<td>Two front doors; cross system conversations on individual cases with signed releases of information</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Same reception; some joint service provided with two providers with some overlap</td>
<td>One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model</td>
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<td>Services</td>
<td>Separate and distinct services and treatment plans; two physicians prescribing</td>
<td>Separate and distinct services with occasional sharing of treatment plans for Q4 consumers</td>
<td>Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;</td>
<td>Q1 and Q3 one physician prescribing, with consultation; Q2 &amp; 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers</td>
<td>One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work</td>
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<tr>
<td>Funding</td>
<td>Separate systems and funding sources, no sharing of resources</td>
<td>Separate funding systems; both may contribute to one project</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding with shared on-site expenses, shared staffing costs and infrastructure</td>
<td>Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility</td>
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<td>Governance</td>
<td>Separate systems with little of no collaboration; consumer is left to navigate the chasm</td>
<td>Two governing Boards; line staff work together on individual cases</td>
<td>Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4</td>
<td>Two governing Boards that meet together periodically to discuss mutual issues</td>
<td>One Board with equal representation from each partner</td>
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<td>EBP</td>
<td>Individual EBP’s implemented in each system;</td>
<td>Two providers, some sharing of information but responsibility for care cited in one clinic or the other</td>
<td>Some sharing of EBP’s around high utilizers (Q4) ; some sharing of knowledge across disciplines</td>
<td>Sharing of EBP’s across systems; joint monitoring of health conditions for more quadrants</td>
<td>EBP’s like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants</td>
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<tr>
<td>Data</td>
<td>Separate systems, often paper based, little if any sharing of data</td>
<td>Separate data sets, some discussion with each other of what data shares</td>
<td>Separate data sets; some collaboration on individual cases</td>
<td>Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups</td>
<td>Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source</td>
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Models/Strategies for 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)
The Four Quadrant Clinical Integration Model

<table>
<thead>
<tr>
<th>Quadrant II: High BH/Low PH</th>
<th>Quadrant IV: High BH/High PH</th>
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<tbody>
<tr>
<td>• BH Case Manager w/responsibility for coordination w/PCP</td>
<td>• PCP with screening tools</td>
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<tr>
<td>• PCP with tools</td>
<td>• BH Case Manager with Coordination with Care Management and Disease Management</td>
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<tr>
<td>• Specialty BH</td>
<td>• Care/Disease Management</td>
</tr>
<tr>
<td>• Residential BH</td>
<td>• Specialty medical/surgical</td>
</tr>
<tr>
<td>• Crisis/ER</td>
<td>• Specialty BH</td>
</tr>
<tr>
<td>• Behavioral Health IP</td>
<td>• Residential BH</td>
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<tr>
<td>• Other Community Supports</td>
<td>• Crisis/ER</td>
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<tr>
<td></td>
<td>• BH and medical/surgical IP</td>
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<td>• Other community supports</td>
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Stable SPMII 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.

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<th>Quadrant 1 – Low BH/Low PH</th>
<th>Quadrant III: Low BH/High PH</th>
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<tr>
<td>• PCP (with standard screening tools and BH practice guidelines)</td>
<td>• PCP with screening tools</td>
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<tr>
<td>• PCP- Based BH *</td>
<td>• Care/Disease Management</td>
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<td></td>
<td>• Specialty medical/surgical</td>
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<tr>
<td></td>
<td>• PCP based- BH</td>
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<td></td>
<td>• ER</td>
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<td></td>
<td>• Medical Surgical IP</td>
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<td></td>
<td>• SNF/home based care</td>
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<td>• Other community supports</td>
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</table>
Quadrant 1 – 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
Working with MCOs

MCOs can plan a leadership role in convening groups and facilitating integration through:

- Policies
- Financing
- Partnering and supporting integration with
  - Utilization Review
  - Data
  - Infrastructure

www.samhsa.integration.gov

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