



Uniting the Mind and Body: State and National Trends and Evidence- Based Practice in Integrated Care

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Session Overview

Context and Need

Elements of Integration

Research, Models, Approaches

Barriers to Integration

Integration Exercise

Integrated Care: Context and Need

- People want to get care in settings where they feel comfortable and already receive services
- Physical health conditions are linked with or exacerbated by mental health conditions
- Mental disorders are the leading cause of disability for individuals ages 15 – 44, affecting one quarter of the population over age 18
- Persons with serious mental illness die 25 years earlier than the general population

Integrated Care: Context and Need

- Institute of Medicine: Crossing the Quality Chasm 2001
- President's New Freedom Commission 2003
- IOM: Improving the Quality of Health Care for Mental and Substance Use Conditions 2006

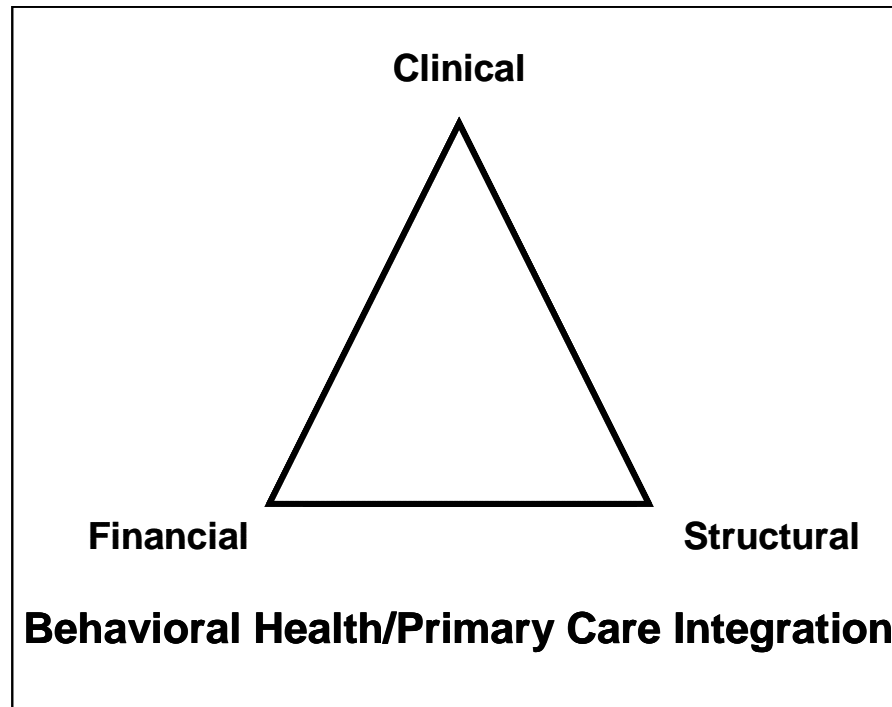
Health Care Integration: What Maine People Want

- Maine people have low expectations for integration of care. To most . . . care integration is a referral and nothing more.
- People believe that a consistent relationship with a primary care provider and co-location of services make integrated care more likely.

Elements of Integrated Care

- No single definition
- Some core elements consistent across approaches
- Consider the care delivery, reimbursement, and organizational aspects of integration

Elements of BH/PC Integration



Integrated Behavioral Health Program

- Delivery System Design
- Financing
- Regulatory
- Workforce
- HIT

Elements of Clinical Care Process

- Screening
- Patient Education
- Patient Self-management Skills
- Psychotherapy
- Mental Health Specialists Involvement
- Clinical Adherence Monitoring
- Standardized Follow-up
- Formal Stepped Care

Characteristics of Integrated Care Programs

- Case Identification/Screening
- Provider Teams
- Enhanced Communication
- Location of Mental Health
- Shared Medical Records
- Decision-making

Doherty/Baird Scale with Reynolds Adaptation

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

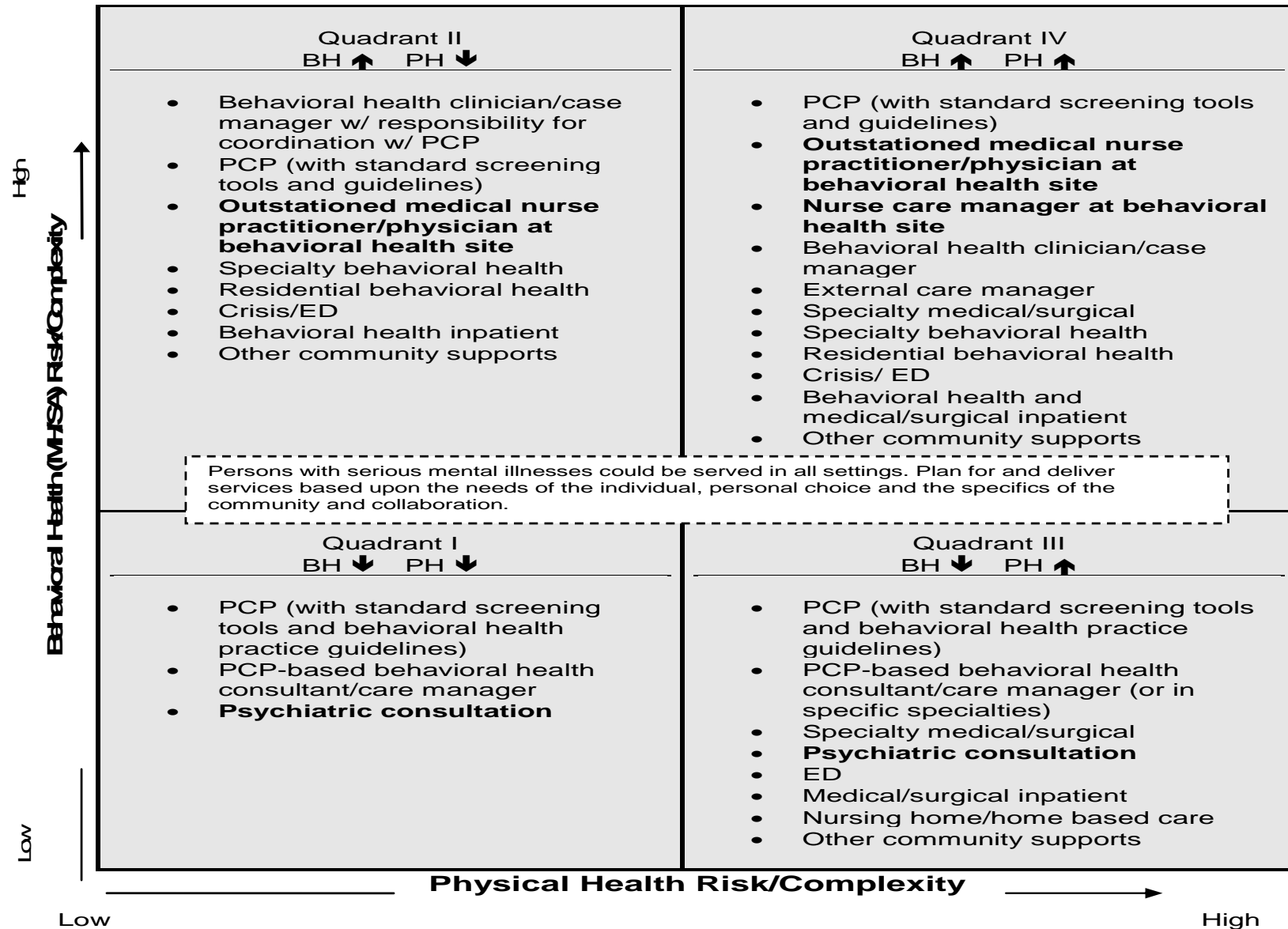
Relevant Research, Models and Approaches

- Frameworks and Theoretical Approaches
- Examples of Research-Based Programs
- Examples of Practice-Based Programs

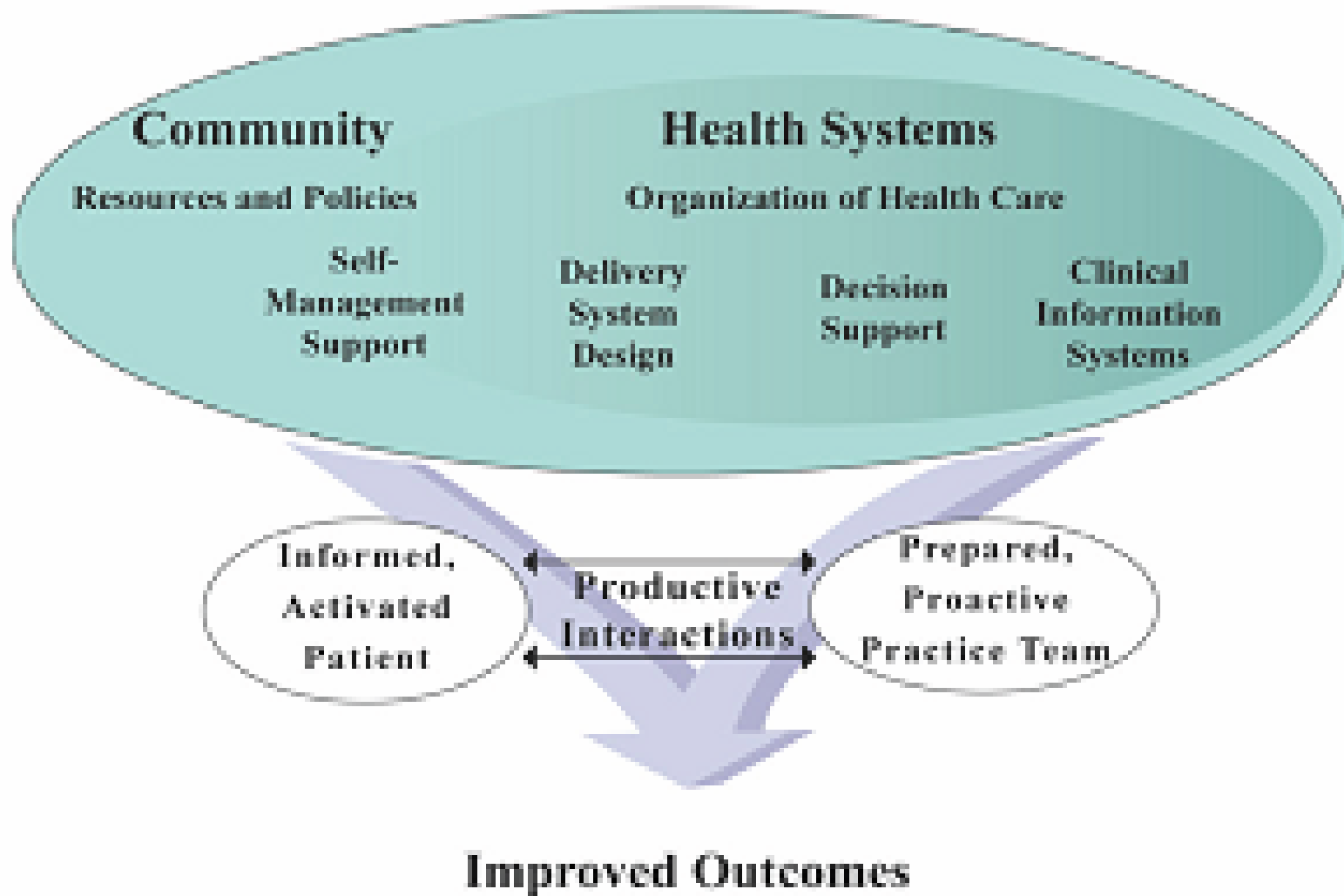
Frameworks and Theoretical Approaches

- Four Quadrant Model
- Chronic Care Model
- Patient-Centered Medical Home

The Four Quadrant Clinical Integration Model



The Chronic Care Model



Developed by The MacColl Institute
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Patient Centered Medical Home (Person Centered Healthcare Home)

- The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

Developed by the AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians.

- Person Centered Healthcare Home—NCCBH and others

Examples of Research-Based Programs

- MacArthur

- RWJF

- IMPACT

- Diamond

IMPACT

- Collaborative Care
- Care Manager
- Designated Psychologist
- Outcome measurement
- Stepped care

Examples of Practice-Based Models

- Cherokee Integrated Program
- Intermountain Healthcare
- South-Central Foundation
- Washtenaw
- Kaiser-Permanente

Cherokee Health Systems

- Behaviorist on the Primary Care Team (Behavioral Health Consultant, or BHC)
- Services: BHC provides brief, targeted, real-time interventions to address psychosocial aspects of primary care
- PCP determines that psychosocial factors are impacting response to treatment
- PCP “hands off” the patient to the BHC for assessment or intervention

Barriers to Integrated Care

- Reimbursement policies and payment rates
- Licensure, credentialing and scope of practice regulations
- Different professional cultures and practice
- Variable understanding/agreement on core elements
- Information sharing/Information technology
- Patient-level barriers

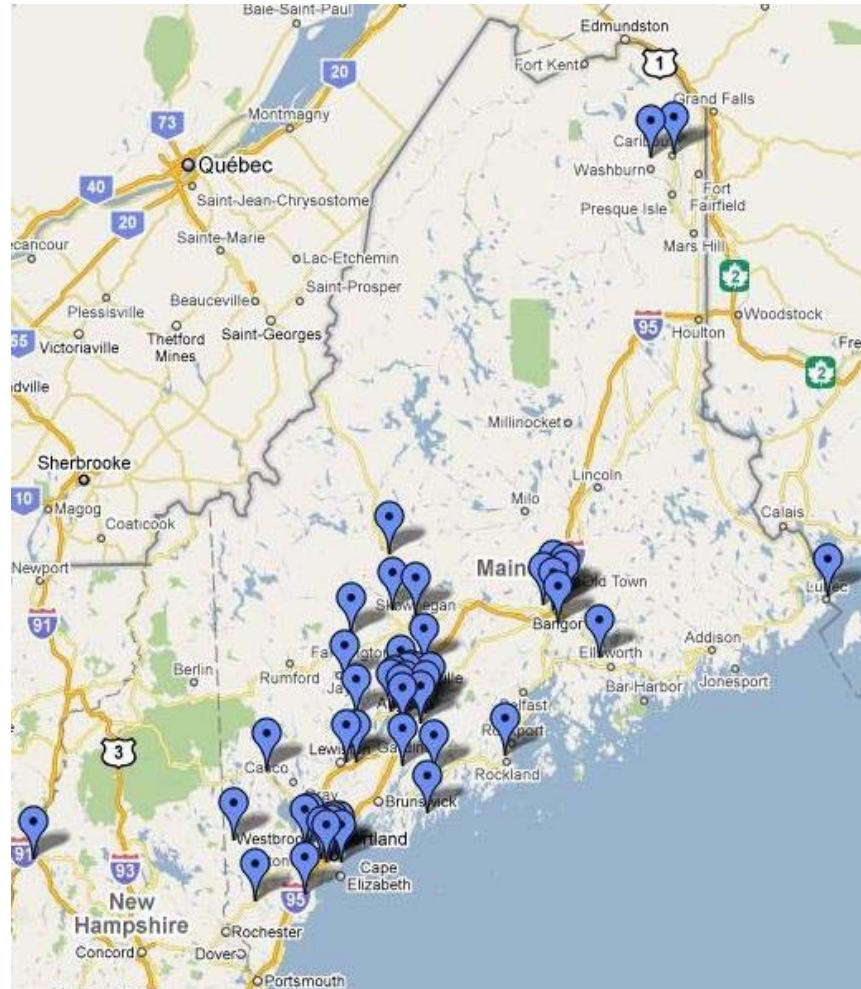
MeHAF's focus on Patient and Family-Centered Care

- One of three organizational priorities with
 - Strengthening the Safety Net
 - Advancing Health Reform
- Implemented largely through the Integration Initiative

MeHAF Response: Integrated Care Initiative

- Three rounds of funding (2007-2009) for 5 years of funding
- Learning Community
- Research, Evaluation
- Policy Enhancement

Statewide Coverage



Site Self Assessment

- Assesses status on 18 dimensions of integrated care in two categories
 - Integrated Services and Patient and Family-Centeredness
 - Practice/Organization

Site Self Assessment Exercise

- Review Site Self Assessment (SSA) Dimensions
- Take 3 minutes to characterize your own organization
- Select a facilitator within your group
- Discuss as a group your individual ratings
- Share insights

