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Integrated Care: Charting a Path Forward

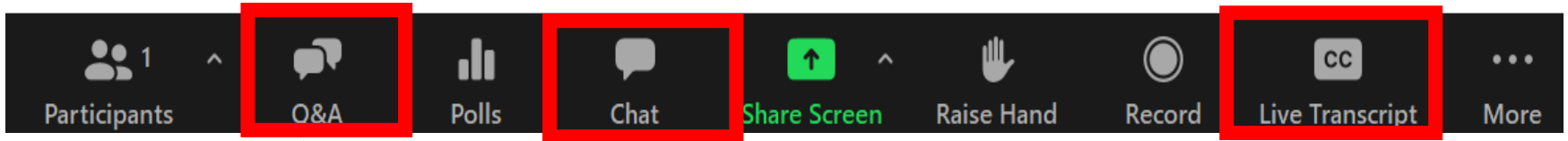
Thursday February 24th, 2022
1:00-2:00pm ET

CENTER OF EXCELLENCE for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**



Type in a **question in the Q&A box**

Click **Live Transcript** and then select **"Show Subtitle"**

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Disclaimer

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Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

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Poll #2: What best describes your organization? (check all that apply)

- Primary Care Provider
- Mental Health Provider
- Substance Use Treatment Provider
- Other (specify in chat box)

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Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)

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Introductions

Joe Parks, M.D.,
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National Council for Mental Wellbeing

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National Council for Mental Wellbeing

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Learning Objectives

After this webinar, participants will be able to:

- **Acknowledge** progress to-date in the field of integrated care.
- **Recognize** limitations and charting a path forward for integrated care.
- **Understand** the background, rationale, and critical need for Comprehensive Health Integration (CHI) and bidirectionality of integrated care services.
- **Participate** in an exclusive look at the soon-to-be released *Comprehensive Health Integration Framework*.

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Why Integrated Care?

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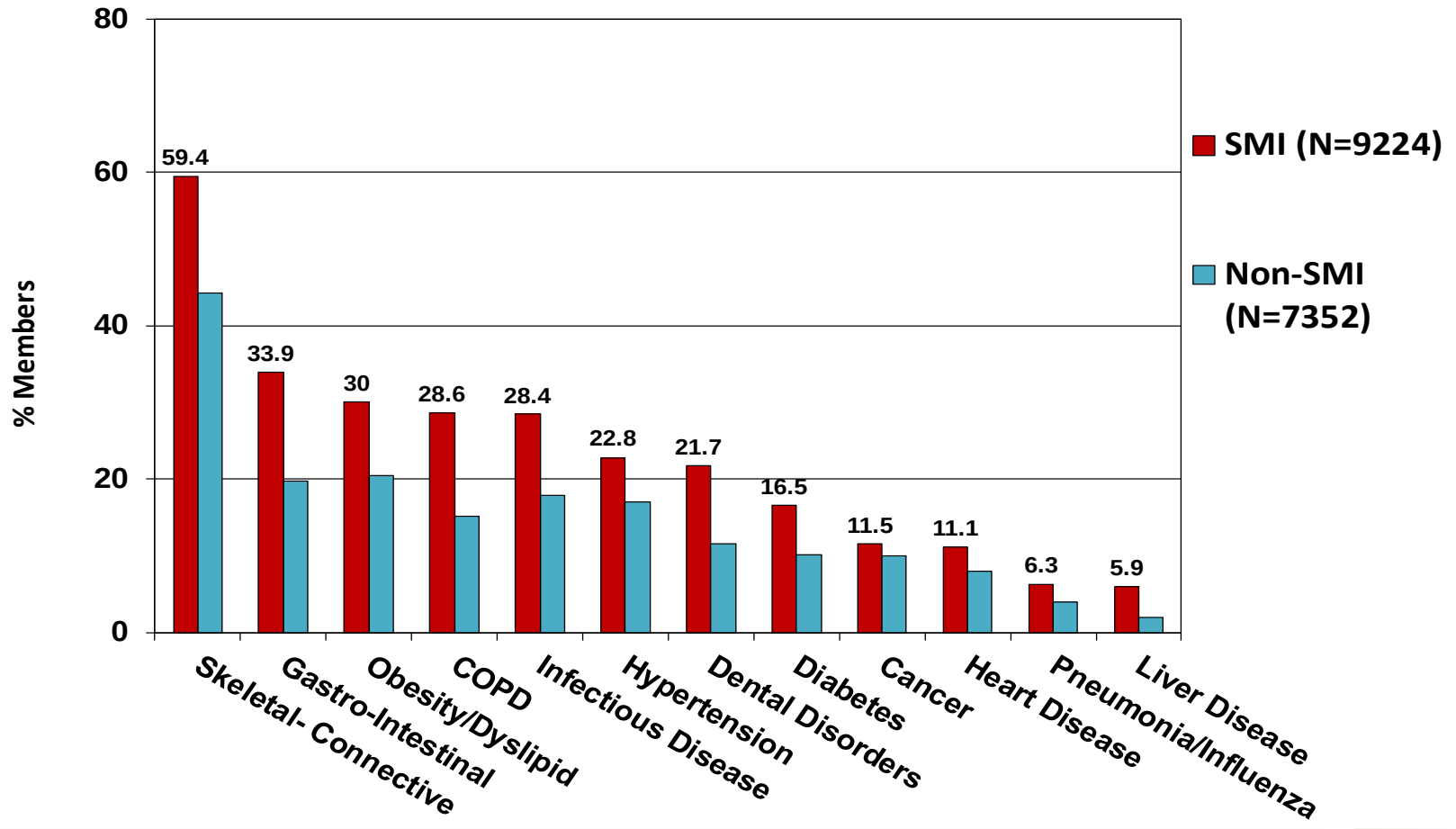
People with SMI have Higher Rates of Chronic Medical Illness



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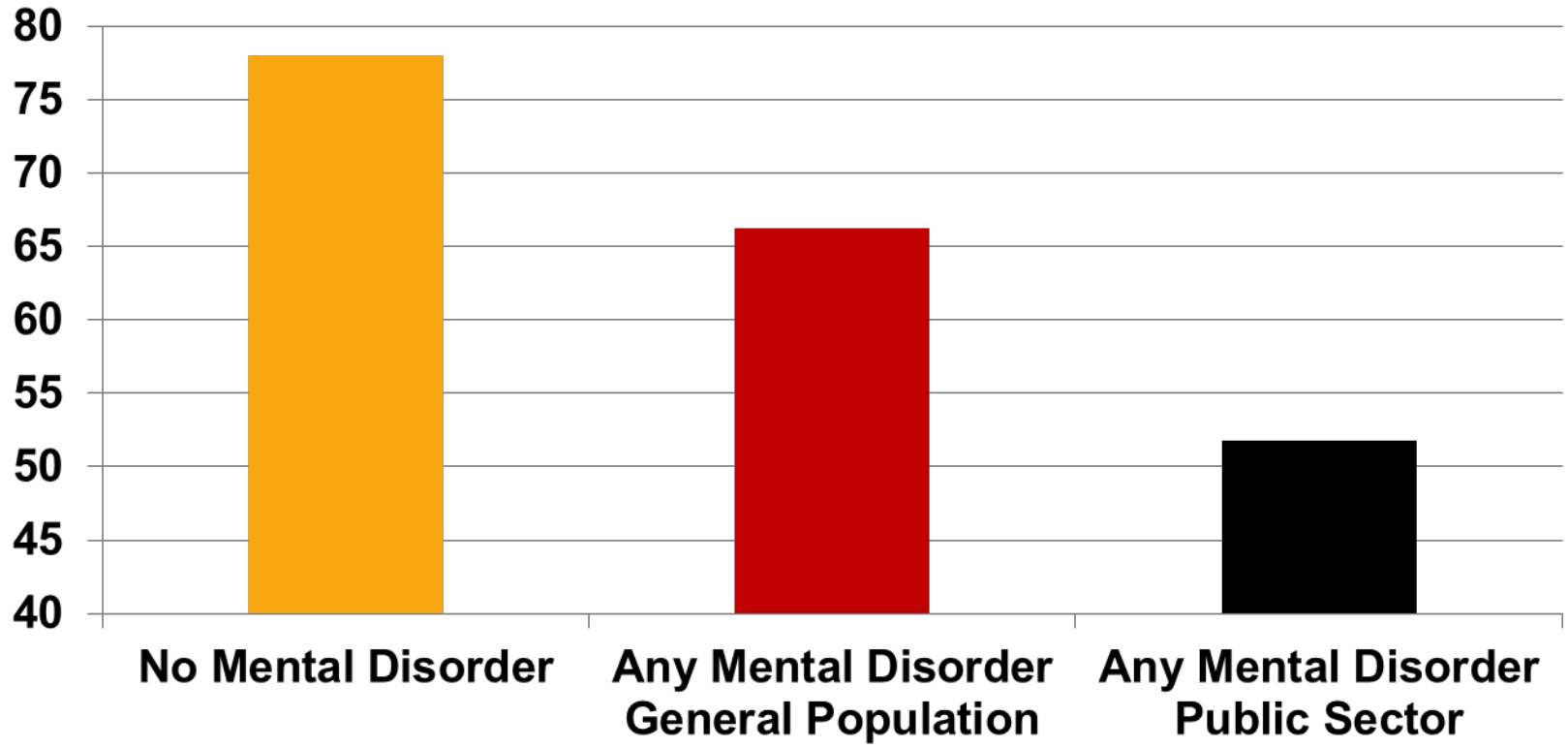
Life Span With and Without Mental Disorder



Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

Bar 3; Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

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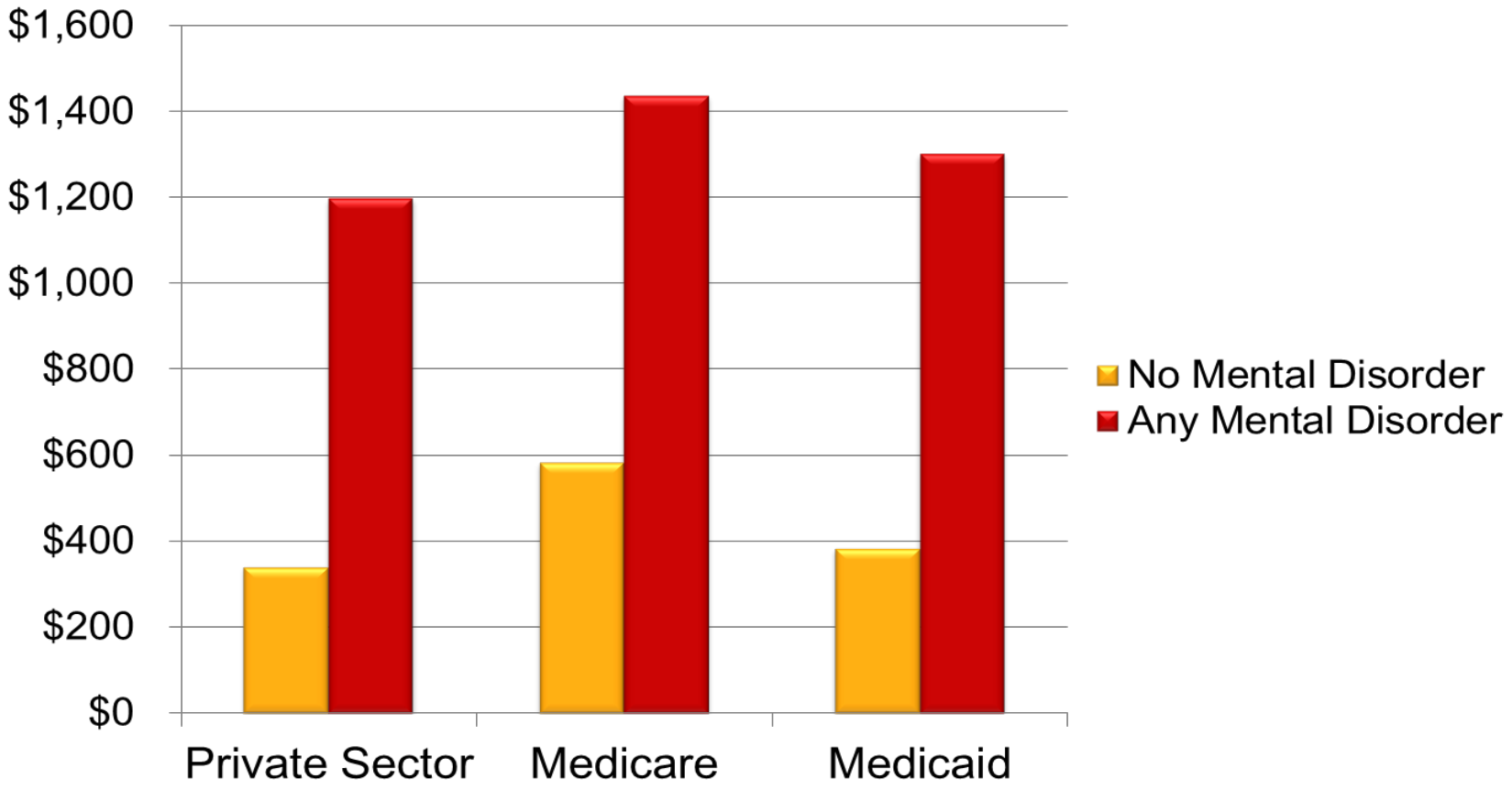
Care for Persons with Mental Disorders is More Costly (PMPM)



Melek et. al, Milliman, Inc., 2013

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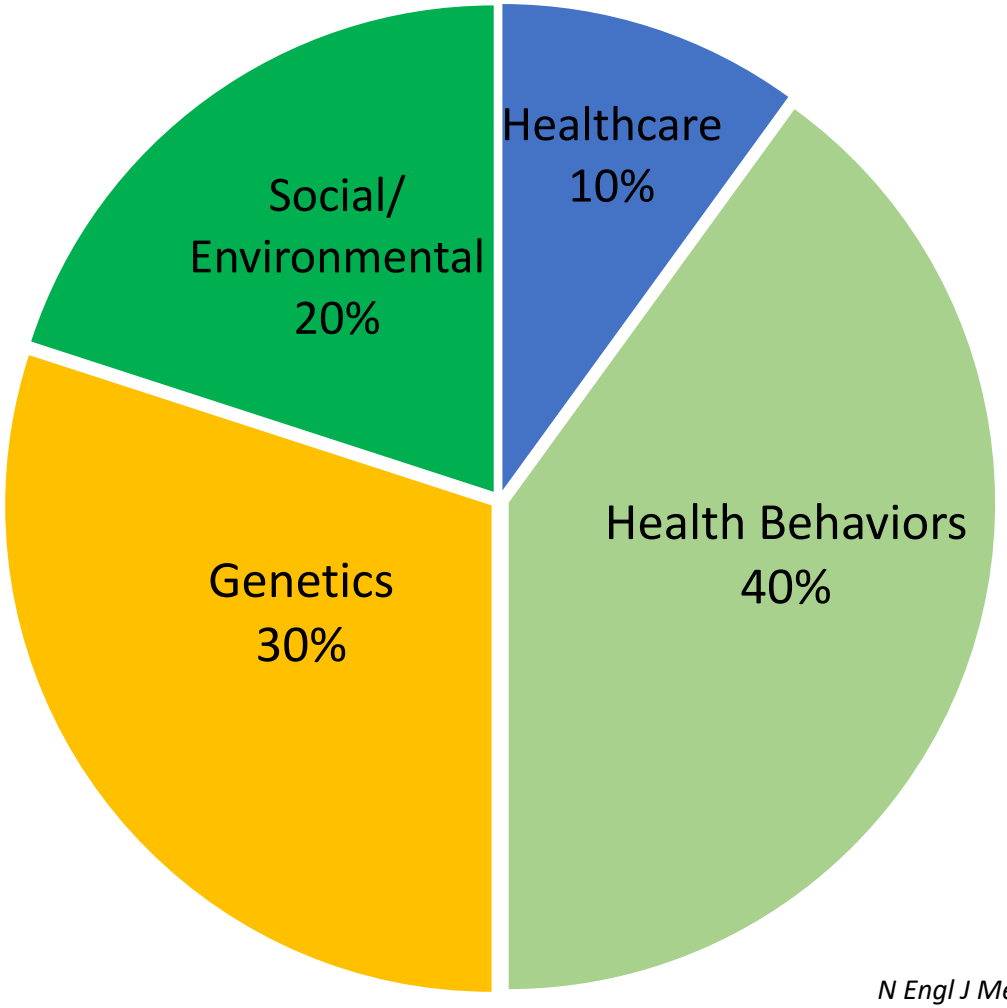
Preventable Causes of Death



N Engl J Med. 2007 Sep 20;357(12):1221-8.

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Without Integration:

- Mental illnesses go undetected and untreated
- When primary care providers detect mental illnesses, they tend to under-treat them
- Populations of color, children and adolescents, older adults, uninsured, and low-income patients more often receive inadequate care for mental health problems
- Substance use care involves same issues, if not worse

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Current State of Integration

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Behavioral Health in Primary Care

- Mild to moderate behavioral health problems are common in primary care 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 behavioral health concern
  - E.g., Diabetes, heart disease, asthma and depression
  - Worse outcomes and higher costs if both problems aren't addressed
- ~1/2 of all care for common psychiatric disorders happens in primary care settings
- Populations of color are even more likely to seek or receive care in primary care than in specialty behavioral health settings

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Why Do People Seek Behavioral Health Care in Primary Care Settings?

- Trust with primary care provider
- Uninsured or underinsured
- Limited access to public mental health and substance use treatment services
- Cultural beliefs and attitudes
- Low availability of mental health and substance use treatment services, especially in rural areas

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Why Primary Care Services in Mental Health?

- High rates of physical illness with mental illness
- Premature mortality
- People with mental illness receive a lower quality of care in primary care settings
- High cost of physical illness with mental illness
- Access problems

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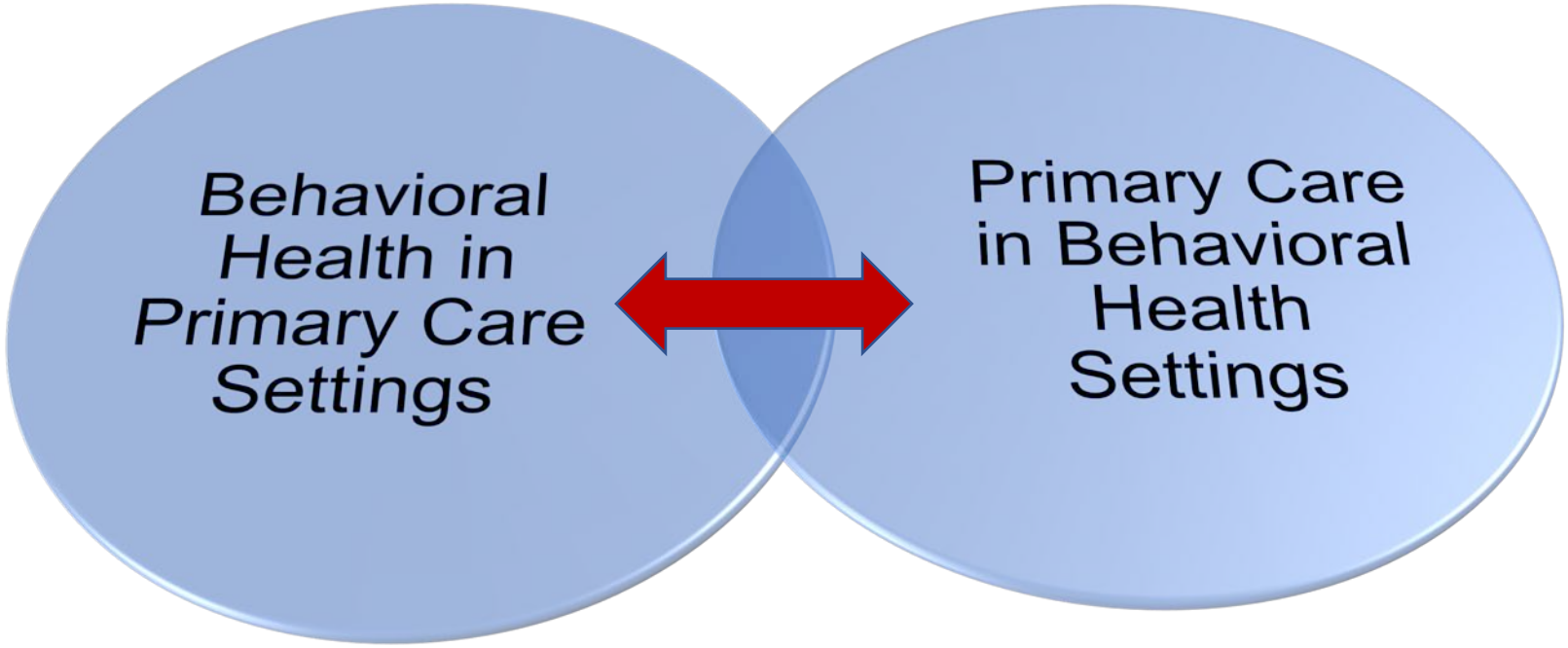
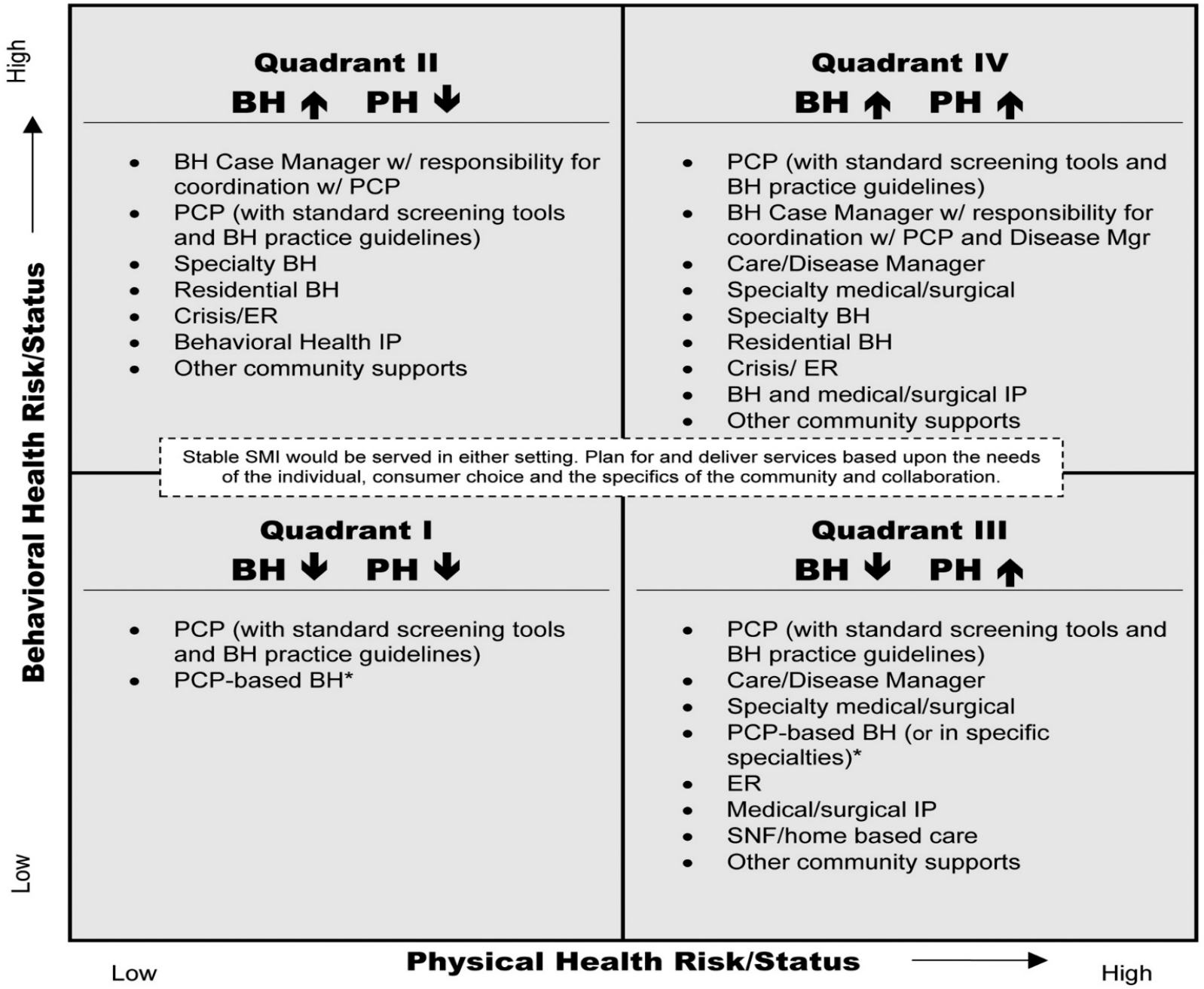
Bidirectional Integration



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

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

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Other Integration Models

- Primary Care Access, Referral and Evaluation (PCARE)
- SAMHSA-HRSA Primary and Behavioral Health Care Integration (PBHCI) Grantees
- 2703 Medicaid State Plan Amendments (SPA)
  - Allow for enhanced Medicaid funding (usually case rate) for Health Home for patients with SMI
  - May be located in a community mental health center, sometimes called a “behavioral health home”

Behavioral Health Consultant

- Psychological problems, such as anxiety and depression
- Substance use disorders and risk reduction
- Psychological components of physical illness, both acute and chronic
- Psychological components of physical illness, both acute and chronic
- Factors impacting health status: stress, non-adherence, health behavior, social support

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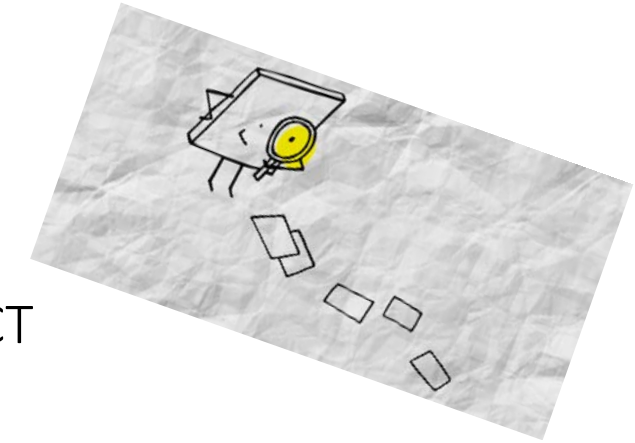
Strongest Evidence Base

Collaborative Care Model (CoCM)



- >25 years of research
- >38 randomized controlled trials, including IMPACT
- A population health management approach
- Adaptation of Wagner's chronic care model

IMPACT Study: J Unutzer, JAMA. 2002;288:2836-2845; and AIMS Center http://impact-uw.org/

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Collaborative Care's Key Ingredients

- **Care management** – Patient education and empowerment, ongoing monitoring, care/provider coordination
- **Evidence-based treatments** – Effective medication management, psychotherapy
- **Expert consultation** for patients who are not improving
- **Systematic diagnosis** and **outcome tracking**
- **Stepped care**
- **Technology support** – registries

J. Unutzer, 2010, www.cimh.org/LinkClick.aspx?fileticket=84F6JQndwg8%3d&tabid=804
S. Gilbody et al, Arch Intern Med. 2006;166:2314-2321

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Screening, Brief Intervention and Referral to Treatment (SBIRT)

Identification of behavioral problems (alcohol, other drug, tobacco, depression, anxiety) and 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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Integrating Primary Care into Behavioral Health Settings

- *Same principles appear to apply*
- **Beginning Steps:**
  - Screening and tracking of basic health indicators for everyone on psychotropic meds
    - Glucose, lipid levels, blood pressure, weight, BMI, etc.
  - Identification of and coordination with the primary care provider
- **Wellness programs**, including peer-led
- Improving primary care access and engagement

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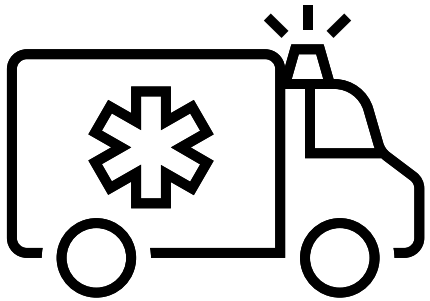
Integrating Behavioral Health into Primary Care

Helpful, but not sufficient in and of themselves:

- Physician training
- Screening
- Referrals
- Co-location of services



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The Medical Home

Patient-Centered Medical Home (PCMH)

- Ongoing relationship with a primary care provider
- Team with collective responsibility for ongoing care
- "Whole person" orientation
- **PCMHs need behavioral health capacity – mental health and substance use services need to be *integrated* into the medical home**

Person-Centered Healthcare Home

- May be a primary care or behavioral health setting depending on a person's preference

- *See www.thenationalcouncil.org for more info on person-centered healthcare homes and the role of behavioral health in medical homes.*
- *See www.pcpcc.net for more about medical homes.*

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Why now?

- **People living with co-occurring Physical Health, Behavioral Health and SDOH needs:**
  - Have higher costs yet experiences poorer health outcomes
  - Are faced with significant inequities based on racial, ethnic, and economic challenges across all settings
  - Are likely to benefit from evidence-based integrated interventions in whatever setting they are best engaged
  - Benefit from higher levels of service intensity
- **Despite progress of knowledge about PH/BH integration, broad uptake remains more limited than the need for these services.**
- **Workforce shortages, exacerbated by the COVID-19 Pandemic, leave gaps in access comprehensive care.**

Bipartisan Policy Center Report

The 2021 BPCR recognized policy barriers that prevent the advancement of integrated care in all PH and BH services, and recommended the following:

- **Define a set of core service elements** necessary for provision of integrated PH and BH services.
- **Identify a set of standardized quality and performance metrics** for practices/programs integrating PH and BH services.
- **Incentivize CCBHCs and FQHCs** to strengthen integration of PH and BH services.
- **Incentivize Medicaid and Medicare** (including through contracted MCOs) to strengthen funding and regulation to support implementation and sustainability of integrated PH and BH services.
- **Develop core integrated care measures** and ensure accountability, particularly with respect to health disparities.

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Overall

- Considerable progression of knowledge on integration, including research defining different methods or models of service delivery,
- Research delineating tools and procedures that support these models, and
- Evidence demonstrating improved outcomes and value for diverse populations.

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But Disappointing Uptake after 15 Years of Work

- Many Healthcare organizations have not attempted to implement any of the current models
- Often implemented as an isolated special project/service instead of a whole organization transformation
- Often not sustained or expanded beyond initial grant funding

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Policy and Implementation Barriers

- Lack of flexibility in implementation of integrated services
- Lack of appropriate bidirectional measures of progress in “integratedness”
- Lack of connection of “integratedness” to value
- Lack of financing to support either implementation or sustainability

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Comprehensive Healthcare Integration (CHI) Framework

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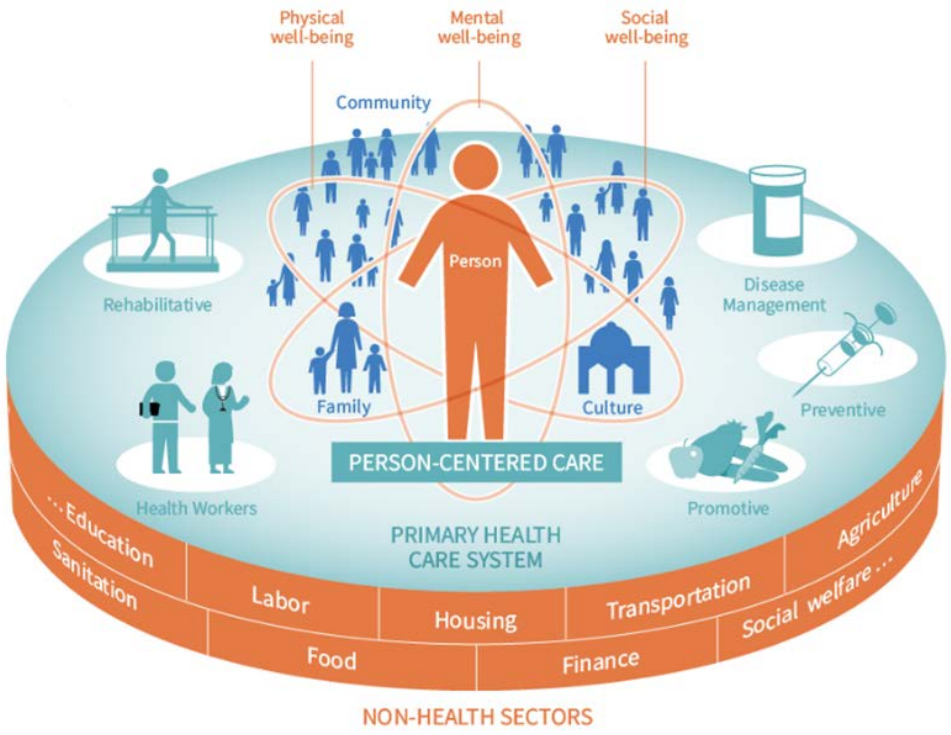
What is the CHI Framework?



The CHI Framework provides guidance on implementing the integration of physical health and behavioral health to help providers, payers and population managers:

- measure progress in organizing delivery of integrated services ("integratedness")
- demonstrate the value produced by progress in integrated service delivery
- provide initial and sustainable financing for integration

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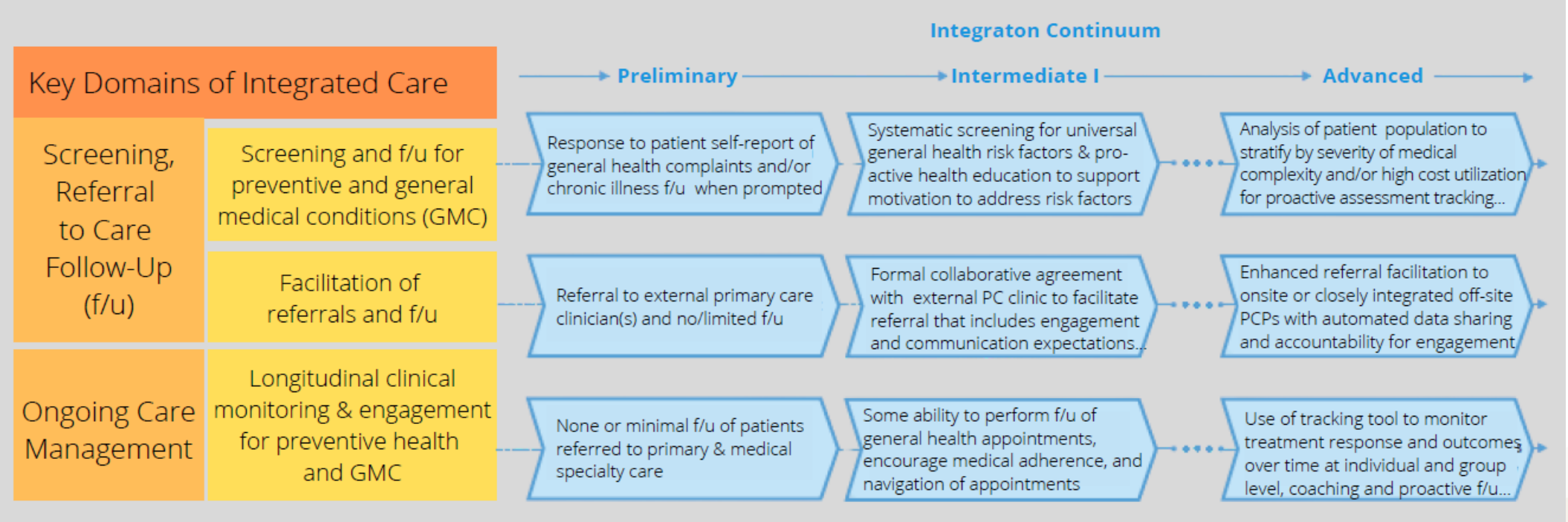
The CHI Framework expands on the General Health Integration (GHI) Framework for BH organizations



Chung, H., Smali, E., Narasimhan, V., Talley, R., Goldman, M.L., Ingoglia, C., Woodlock, D., Pincus, H.A. (2020). Advancing Integration of General Health in Behavioral Health Settings, A Continuum-based Framework. Retrieved from: https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_8.21.20.pdf?daf=375ateTbd56.

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Characteristics of the CHI Framework

- ✓ Broad application
- ✓ Evidence-based domains of integration
- ✓ Measurable standards for integration
- ✓ Self-Assessment Tool
- ✓ Flexibility of achieving successful progress in integration
- ✓ Connection of progress in integration to metrics demonstrating value
- ✓ Connection of payment methodologies to improving value by improving and sustaining integration

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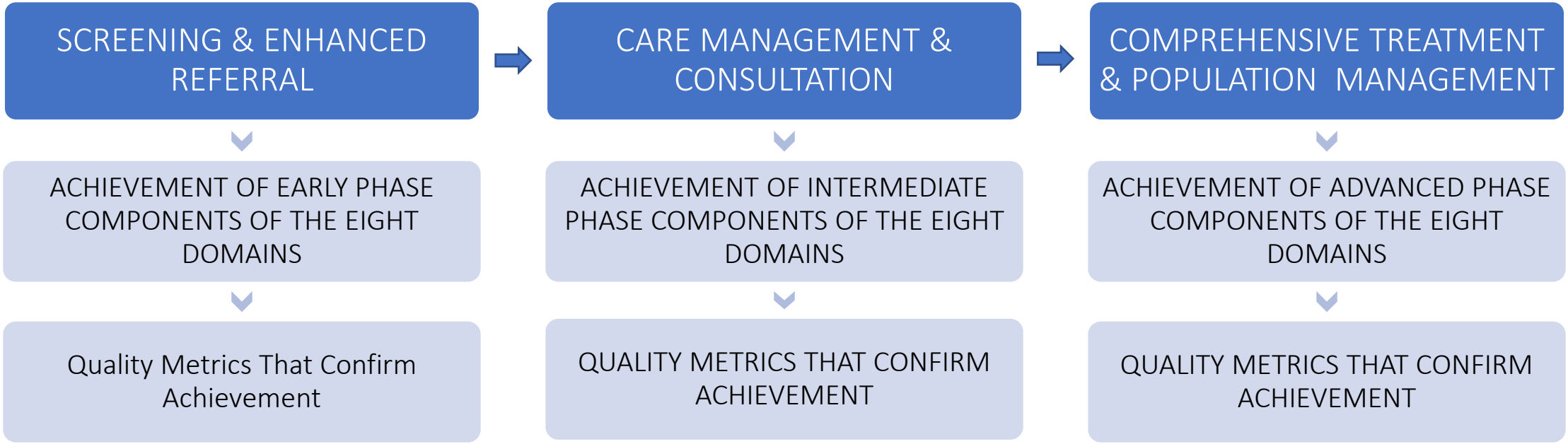
Eight Evidenced Based Integration Domains Within Each of the Three Integration Constructs



CHI Framework Timeline & Learning Opportunities

- Anticipated publication date: March 2022
- NatCon22 Overview Presentation: Monday, April 11
- Spring 2022 CoE Webinars:
  - Webinar #1 – *"Domains & constructs"*
  - Webinar #2 – *"Measure integration & choosing metrics"*
  - Webinar #3 – *"Payment models"*
  - ** Webinar topics may change*
- Winter 2022 ECHO - Learning Community

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Questions & Comments?

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Tools & Resources

National Council for Mental Wellbeing

- Center of Excellence for Integrated Health Solutions – Resource Home Page
- CIHS Standard Framework for Levels of Integrated Care
- CIHS Essential Elements of Effective Integrated Primary Care & Behavioral Health Teams
- General Health Integration Framework – Advancing Integration of General Health in BH Settings
  - Utilizing an Evidence-based Framework to Advance Integration of General Health in Mental Health and Substance Use Treatment Settings – Blog post
- Medical Director Institute – Home Page
- High-Functioning Team-Based Care Toolkit
- Organizational Assessment Toolkit for Primary & Behavioral Health Care Integration (OATI)
- Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers

Other

- Agency for Healthcare Research & Quality – Implementing a Team-Based Model in Primary Care Learning Guide
- Health & Medicine Policy Research Group – Behavioral Health Primary Care Integration

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Upcoming CoE Events:

Advancing General Health Integration in Behavioral Health: Mid-Year Findings

Register for the webinar on Monday, February 28, 12-1pm ET

Social Determinants of Health Part 1: Screening for Patient Social Risks in Integrated Care Settings

Register for the webinar on Thursday, March 3, 3-4pm ET

Interested in an individual consultation with the CoE experts on integrated care?

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Thank You

Questions?

Email integration@thenationalcouncil.org

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