

Key Principles for Making Integrated Care Successful Across Settings

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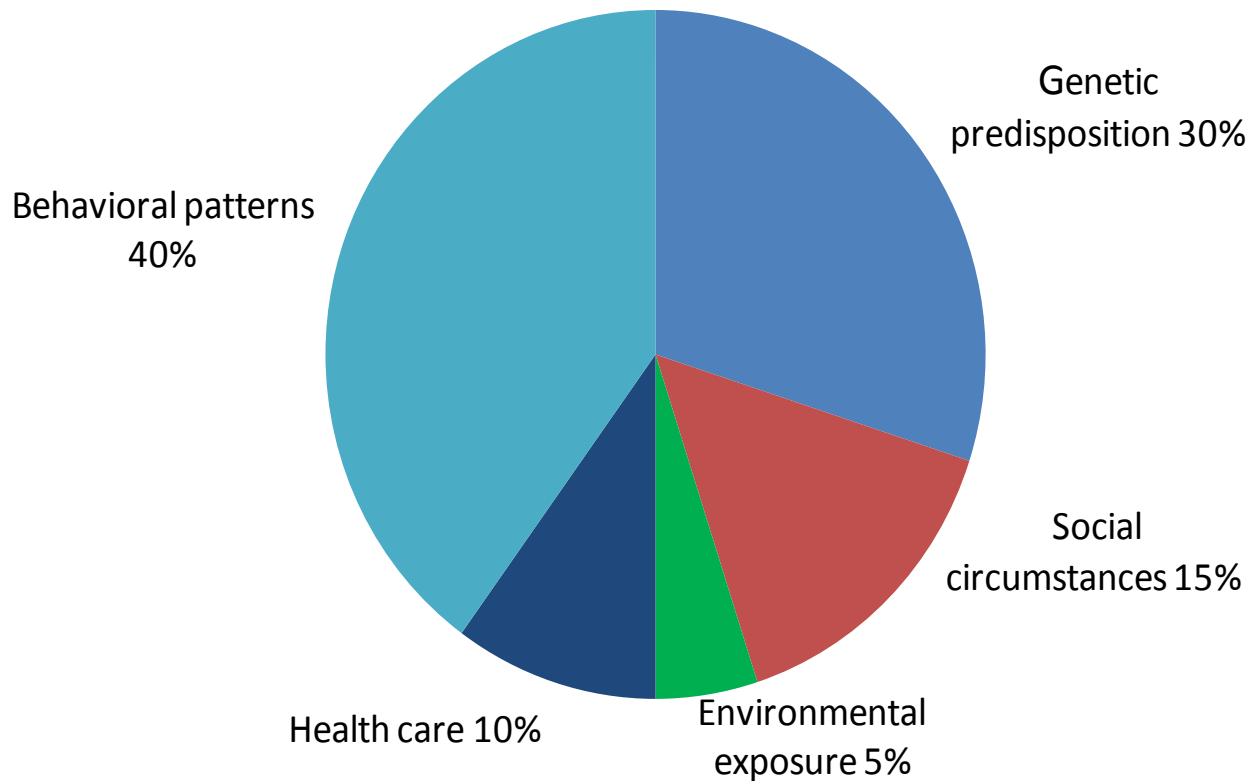
Medical Director, Behavioral Health Integration

www.mainehealth.org/behavioralhealthintegration

OVER TWO DECADES OF CALLS FOR INTEGRATED CARE

- Surgeon General report
- Institute of Medicine Quality Chasm Reports
- President's New Freedom Commission
- Agency for Healthcare Research and Quality (AHRQ)
- Affordable Care Act (ACA, Obamacare)

Contribution to Premature Mortality



INTEGRATED CARE:

“...Unifies care for physical and mental concerns”

“In general, integrated care achieved positive outcomes.”

“...avoid premature orthodoxy.”

Butler M, Kane R.L, McAlpine D, Kathol R.G., Fu S.S., Hadorn H. & Wilt T.J. (2008). Agency of Healthcare Research and Quality. (2008). *Integration of Mental Health/Substance Abuse and Primary Care. Agency of Healthcare Research and Quality Publication 09-E003.* Rockville, MD.

Mental Health Services in the Medical Home

“... the Patient Centered Medical Home will not reach its full potential without adequately addressing patients’ mental health needs. Doing so, however, will likely shift responsibility for the delivery of much mental health care from the mental health sector into primary care...

...a change that many stakeholders will likely oppose.”

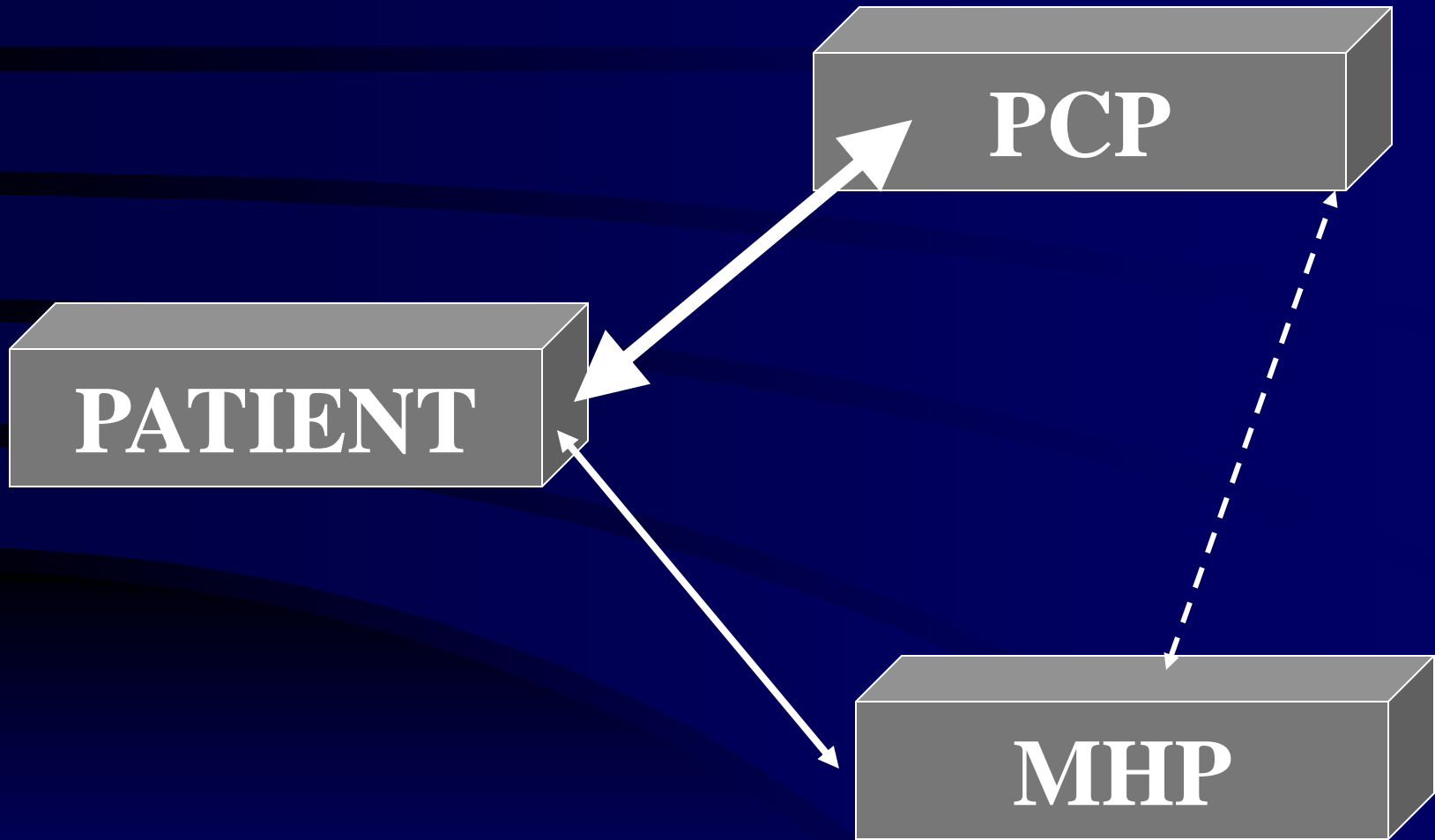
Croghan TW, Brown JD. Integrating Mental Health Treatment Into the Patient Centered Medical Home. AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

Consensus definition of Integrated Care

- *The care a patient experiences as a result of a 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 (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.*

From: AHRQ Integration Academy; Peek, et al: Lexicon for behavioral health and primary care integration

Usual Care



Many Models and Terms

- Collaborative care
- Integrated care
- Co-located care
- Behavioral health consultant
- Mental health/behavioral health
- Co-located collaborative care
- Integrated care
- Health psychology
- Care management
- Case management
- Care coordination
- Primary care
- Enhanced referral



Essentially, all models are wrong, but some are useful.

(George E. P. Box)

izquotes.com

What do the models have in common?

- Co-location
 - necessary but not sufficient
 - Can be virtual
- Decision support
- Brief, problem focused interventions
- Team based care with clearly defined roles
- Population management, not caseload
- Measurement

VA integrated care

- Blend of collaborative care (care management) and embedded MH providers
- Same day access (goal 80%)
- Primarily addresses common, uncomplicated illness and behaviorally sensitive non psychiatric illness
- Initial system-wide rollout 2007-8

Our clinicians' roles on the medical home team

- Support Patient Self-Management
- Provide brief assessment and MH interventions
- Support MH treatment provided by PCP
- MH subject matter expert in primary care
- Support round trip ticket to specialty MH care
- MH treatment plan is part of care plan, not separate
- Population-based, stepped care
 - Providing a clinical pathway opens the door to universal screening

Published outcomes to date (from national* and local data)

- Increased identification and treatment in the population—particularly females and older patients*
- Reduction in referral rate into specialty MH care
- Improved likelihood that patients screening positive for depression receive guideline-concordant care.
- High levels of clinician acceptance of measurement
- Reduced no-show rates and higher engagement rate for those referred into specialty MH care.*

The psychiatrist shortage

Which one of these statements is the problem?

- There will not be enough psychiatrists to match the growing demand for treatment of mental disorders
- There will not be enough access to assessment and treatment to meet the growing demand for treatment of mental disorders

“...the profession may soon be facing the prospect of an oversupply of psychiatrists. Given the present rate of producing psychiatrists, shifts in demands for psychiatric services, changing payment and access patterns regarding specialty medical care, increasing numbers of nonpsychiatrist mental health professionals, and a probable surfeit of primary care physicians, underemployment of psychiatrists may become commonplace. Future psychiatrists will likely be used more as consultants, and the profession will need fewer, but better trained, graduates.”

Yager J, Borus JF Are we training too many psychiatrists? *American Journal of Psychiatry* 1987
Aug;144(8):1042-8.

FIRST, BE OF USE.

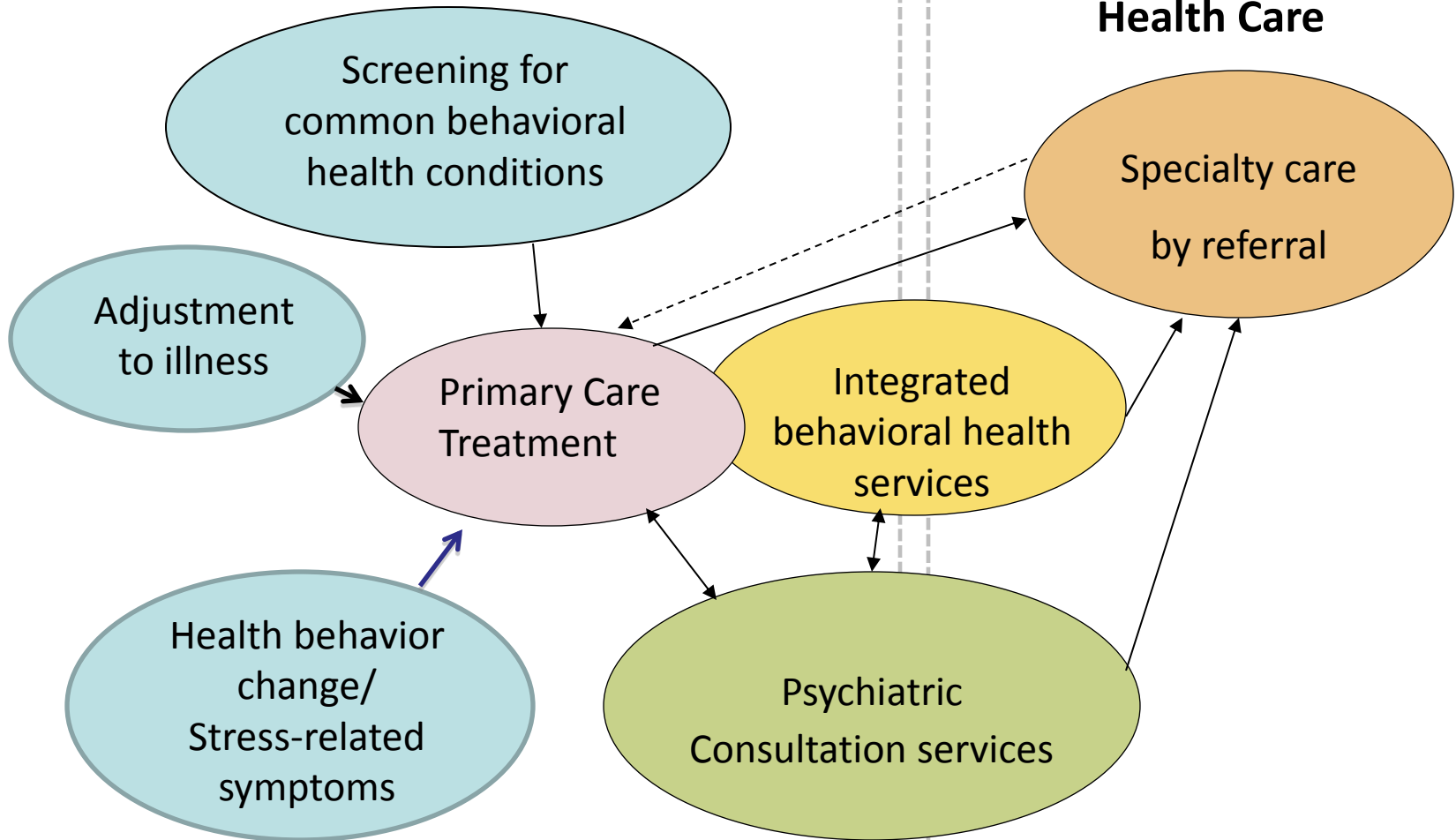
G. Engel

History of Maine Health's Behavioral Health Integration Program

Years	Activity
2002-2004	MacArthur Foundation Initiative on Depression in Primary Care
2003-2007	RWJ Foundation Depression in Primary Care Program
2007-2010	MeHAF Behavioral Health Integration Program
2010-2013	Transition to sustainability
2014-Present	Sustainable clinical service

Primary & Specialty Medical Health Care

Specialty Behavioral Health Care



Behavioral Health Clinician model

- Behavioral health clinician (BHC – most often psychologist or LCSW) works side by side with PCPs
 - Brief, problem-focused treatment approach
 - Warm handoffs
 - Broadly applied to mental health problems and to behavioral and psychosocial aspects of physical health problems

Child psychiatry access program

- Phone access to triage service that might help with:
 - Telephone consultation between PCP and child psychiatrist
 - Evaluation of child by psychiatrist
 - Referral for specialty mental health services
 - Referral to community organization
- Provider lunch and learns and other educational activities

Workforce Development

- Monthly and as needed supervision by LCSW experienced in integrated care
- Group case review with psychiatrist monthly
- Quarterly training and team building for all integrated clinicians across the system

How do we use psychiatrists?

- Monthly and ad hoc case reviews with integrated social workers
- Informal consultation through the EMR
- Lunch and learn didactic and case based teaching
- Phone advice to PCPs

Proposed MaineHealth Dashboard

Operational/Financial	Clinical
Productivity/ Access/ No show rate* Data on demographics and clinical characteristics of patients referred for integrated care Financial performance vs, budget Cost of care – total and by target population/condition	Depression screening and follow up* Depression remission Clinical measures appropriate for target populations/conditions
Experience/Satisfaction	Functional/Quality of Life
Patient experience/satisfaction with integrated services Provider*/Staff satisfaction	Measure of general function or quality of life (e.g. SF-12, PROMIS-10)

* Currently measuring at practice level



Start where you are
Use what you've got
Do what you can

Arthur Ashe

Useful Websites

- Advancing Integrated Mental Health Solutions, Univ. of Washington - www.uwaims.org
- AHRQ Integration Academy - <http://integrationacademy.ahrq.gov/>
- American Psychiatric Association – www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care
- Collaborative Family Healthcare Association – www.cfha.net
- SAMHSA-HRSA Center for Integrated Health Solutions - www.integration.samhsa.gov
- <http://www.mirecc.va.gov/cih-visn2/> VA CoE: VA Center for Integrated Healthcare