Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

April 2021

Integrated Care in Primary Care: A Continuum

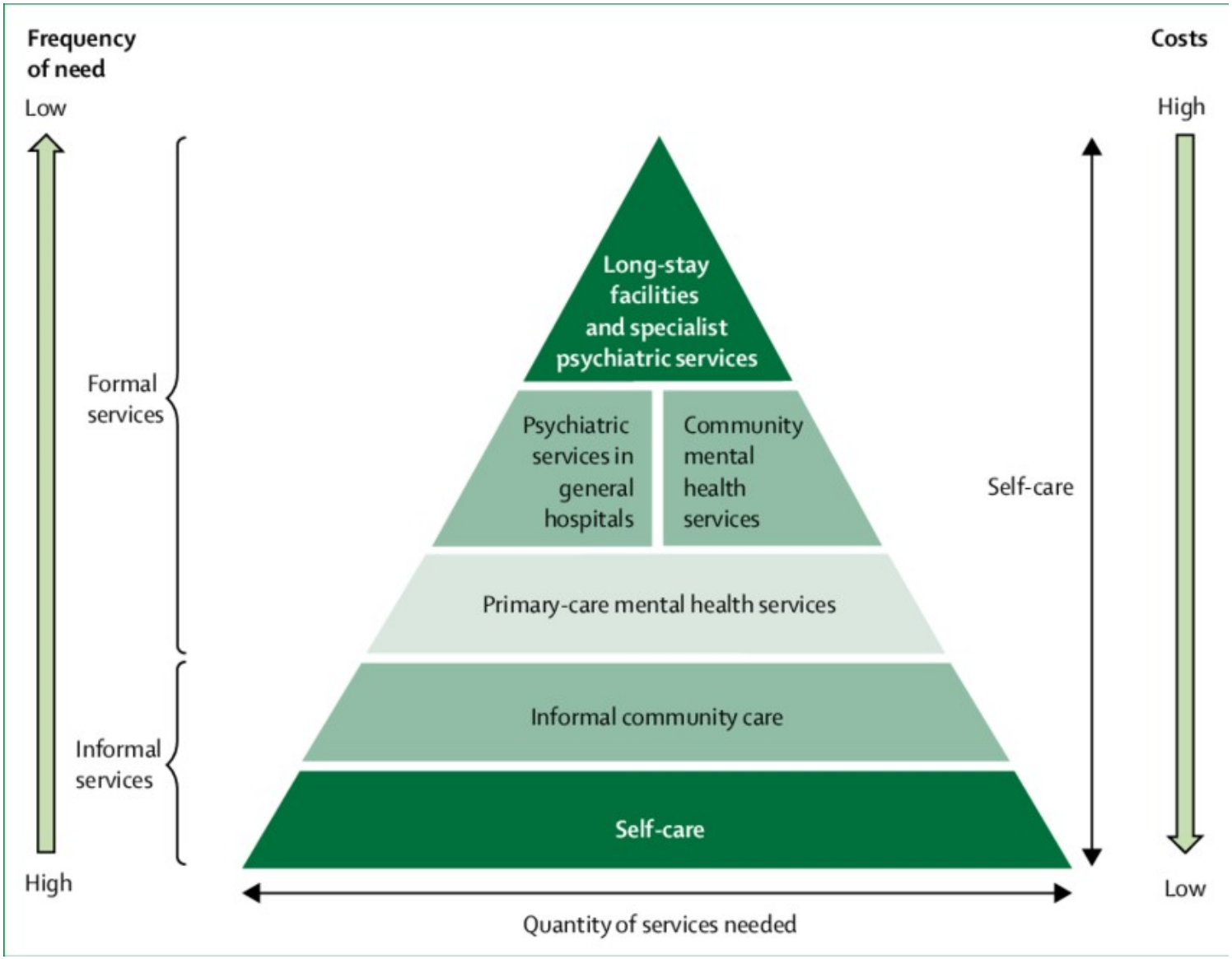
ICTP Pathway April 2021

What is integrated care?

Integrated Care

Team-based care provided to individuals of all ages, families, and their caregivers in a whole-person oriented setting or settings by licensed primary care providers, behavioral health clinicians, and other care team members working together to address one or more of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization.

- Bree Collaborative Behavioral Health Integration Report, 2017
(Founded 2011, Consortium of stakeholders "to improve quality, health outcomes, and cost effectiveness of care in Washington State.")



Why integrated care?

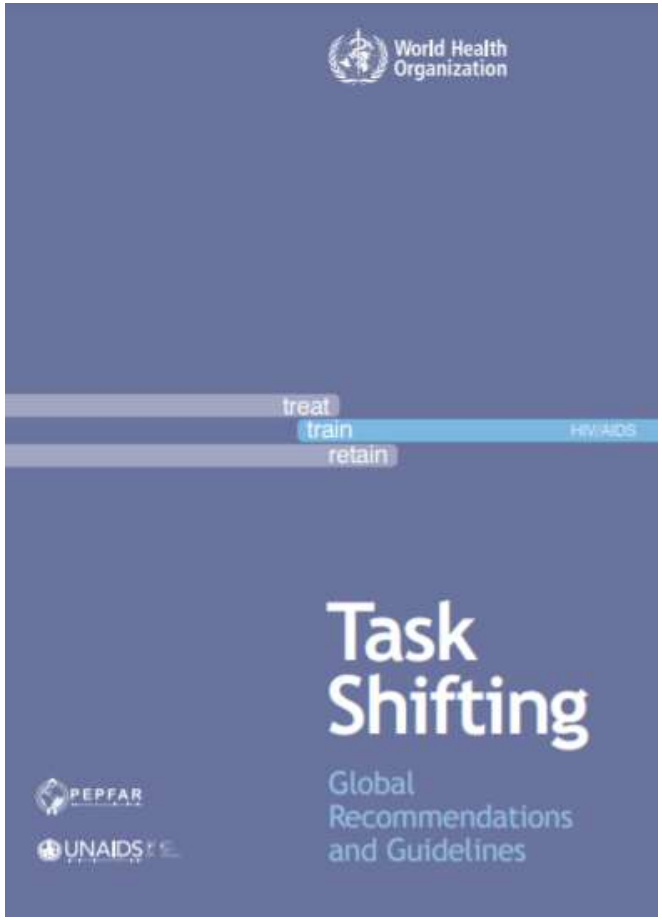
Rationale for Integrating Mental Health into Primary Care
The burden of mental health disorders is great
Mental and physical health problems are interwoven
The treatment gap for mental disorders is enormous
Primary care for mental health enhances access
Primary care for mental health promotes respect of human rights
Primary care for mental health is affordable and cost-effective
Primary care for mental health improves clinical outcomes

Rationale for integrating mental health care into primary care, as proposed by WHO and Wonca 2008

What does integrated care look like?

Examples

- Co-located (ex: SCCA)
- Primary Care Behavioral Health (PCBH)
- VA Primary Care Mental Health Integration (PCMHI)
- Task shifting (WHO)
- Collaborative Care (AIMS model)



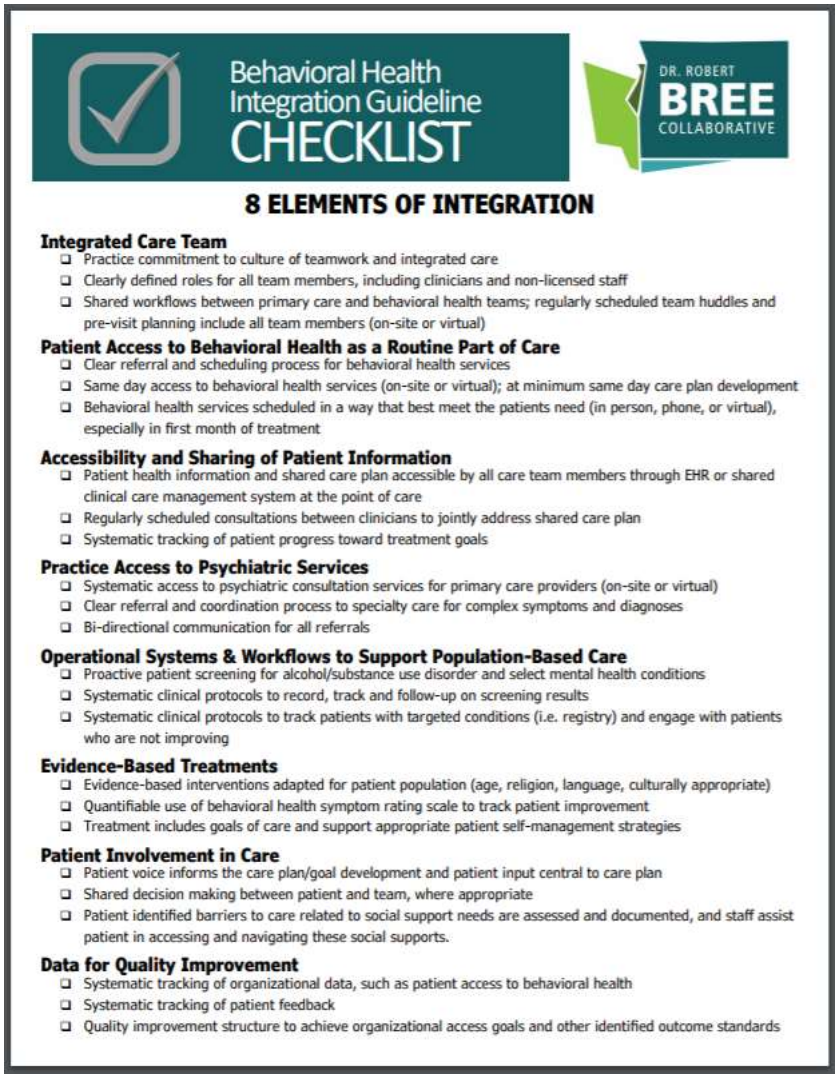
What are core elements of integrated care?

- Behavioral Health Integration Report (March 2017) and self-assessment tools
  - "… focus on functions or minimum standards that could be used across settings for which practices would not have to hire additional on-site staff."
- Lexicon for Behavioral Health and Primary Care Integration (AHRQ 2013)

Bree Collaborative Checklist

8 Elements of Integration

- Integrated Care Team
- Patient Access to BH Care
- Sharing of Patient Info
- Access to Psychiatric Services
- Operational Systems and Workflows to Support Population-Based Care
- Evidence-Based Treatment
- Patient Involvement
- Data for Quality Improvement



Behavioral Health Integration Guideline CHECKLIST

DR. ROBERT BREE COLLABORATIVE

8 ELEMENTS OF INTEGRATION

Integrated Care Team
- ❑ Practice commitment to culture of teamwork and integrated care
- ❑ Clearly defined roles for all team members, including clinicians and non-licensed staff
- ❑ Shared workflows between primary care and behavioral health teams; regularly scheduled team huddles and pre-visit planning include all team members (on-site or virtual)

Patient Access to Behavioral Health as a Routine Part of Care
- ❑ Clear referral and scheduling process for behavioral health services
- ❑ Same day access to behavioral health services (on-site or virtual); at minimum same day care plan development
- ❑ Behavioral health services scheduled in a way that best meet the patients need (in person, phone, or virtual), especially in first month of treatment

Accessibility and Sharing of Patient Information
- ❑ Patient health information and shared care plan accessible by all care team members through EHR or shared clinical care management system at the point of care
- ❑ Regularly scheduled consultations between clinicians to jointly address shared care plan
- ❑ Systematic tracking of patient progress toward treatment goals

Practice Access to Psychiatric Services
- ❑ Systematic access to psychiatric consultation services for primary care providers (on-site or virtual)
- ❑ Clear referral and coordination process to specialty care for complex symptoms and diagnoses
- ❑ Bi-directional communication for all referrals

Operational Systems & Workflows to Support Population-Based Care
- ❑ Proactive patient screening for alcohol/substance use disorder and select mental health conditions
- ❑ Systematic clinical protocols to record, track and follow-up on screening results
- ❑ Systematic clinical protocols to track patients with targeted conditions (i.e. registry) and engage with patients who are not improving

Evidence-Based Treatments
- ❑ Evidence-based interventions adapted for patient population (age, religion, language, culturally appropriate)
- ❑ Quantifiable use of behavioral health symptom rating scale to track patient improvement
- ❑ Treatment includes goals of care and support appropriate patient self-management strategies

Patient Involvement in Care
- ❑ Patient voice informs the care plan/goal development and patient input central to care plan
- ❑ Shared decision making between patient and team, where appropriate
- ❑ Patient identified barriers to care related to social support needs are assessed and documented, and staff assist patient in accessing and navigating these social supports.

Data for Quality Improvement
- ❑ Systematic tracking of organizational data, such as patient access to behavioral health
- ❑ Systematic tracking of patient feedback
- ❑ Quality improvement structure to achieve organizational access goals and other identified outcome standards

http://www.breecollaborative.org/wp-content/uploads/BHI-Guideline-Checklist-1-1.pdf

Integrated care on a continuum

- Bree Collaborative BH Integration Report
- SAMHSA-HRSA Center for Integrated Solutions
  - National training and assistance center
    - promotes the development of integrated behavioral health programs
  - Standard Framework for Levels of Integrated Care

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸▸ Screening and assessment done according to separate practice models ▸▸ Separate treatment plans ▸▸ Evidenced-based practices (EBP) implemented separately	▸▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸▸ Separate treatment plans shared based on established relationships between specific providers ▸▸ Separate responsibility for care/EBPs	▸▸ May agree on a specific screening or other criteria for more effective in-house referral ▸▸ Separate service plans with some shared information that informs them ▸▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸▸ Agree on specific screening, based on ability to respond to results ▸▸ Collaborative treatment planning for specific patients ▸▸ Some EBPs and some training shared, focused on interest or specific population needs	▸▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸▸ Collaborative treatment planning for all shared patients ▸▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸▸ One treatment plan for all patients ▸▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸▸ Patient physical and behavioral health needs are treated as separate issues ▸▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸▸ Patient health needs are treated separately at the same location ▸▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leadership in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often colocation is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

Self-Assessment and Implementation Tools

- Bree Collaborative Checklist and Core Measures
- SAMHSA-CHIS Organization Assessment Toolkit for Primary and Behavioral Health Care Integration
- SAMHSA Quick Start Guide
- MeHAF self assessment tool
- AIMS Center Implementation Guide and Resource Library

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)				
Characteristic	**Levels**			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services **1**	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2 3 4**	. . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5 6 7**	. . . are integrated, with one reception area; appointments jointly scheduled, shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8 9 10**
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	. . . are not done (in this site) **1**	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**

https://www.hca.wa.gov/assets/P4R-physical-behavioral-health-integration-practice-site.pdf

Resources

- SAMHSA-CHIS:
  - https://www.samhsa.gov/integrated-health-solutions
- SAMHSA-CHIS Organization Assessment Toolkit for Primary and Behavioral Health Care Integration:
  - https://www.thenationalcouncil.org/wp-content/uploads/2020/01/OATI_Overview_FINAL.pdf?daf=375ateTbd56
- SAMHSA Quick Start Guide:
  - https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Website-Resources.pdf?daf=375ateTbd56
- SAMHSA Wellness Assessment Tool:
  - https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Wellness_Organizational_Self-Assessment.pdf?daf=375ateTbd56

Resources

- Bree Collaborative Checklist:
  - http://www.breecollaborative.org/wp-content/uploads/BHI-Guideline-Checklist-1-1.pdf
- Bree Collaborative Behavioral Health Integration report:
  - http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
- Lexicon for Behavioral Health and Primary Care Integration (2013)

Resources

- Sunderji, N., Polaha, J., Ratzliff, A., & Reiter, J. (2020). **A walk on the translational science bridge with leaders in integrated care: Where do we need to build?** *Families, Systems, & Health, 38*(2), 99-104.

- Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. **Collaborative care for depression and anxiety problems.** Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525.

- Hunter CL, Funderburk JS, Polaha J, Bauman D, Goodie JL, Hunter CM. **Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action**. *J Clin Psychol Med Settings*. 2018;25(2):127-156.

- Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer A.C., (2009), **Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention.** Washington, DC: American Psychological Association