Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

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Integrated Care Models:

Where does my practice fall on the integrated care spectrum?

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General Disclosures

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Planner Disclosures

The following series planners have no relevant conflicts of interest to disclose:

- Denise Chang, MD
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Overview of Learning Collaborative

- Goals:
  - Provide ongoing integrated care education
  - Foster learning and support network
  - Support sustainment of integrated care
- Structure:
  - Monthly lunch hour on 4th Tuesday
    - Didactic topic 15-20 mins
    - Open discussion remainder of time
  - Topics repeat every 6 months

Learning Objectives

- Identify at least three models of integrating mental health care in primary care setting
- Compare and contrast advantages and challenges associated with different models of integrated care
- Review resources/tools for supporting integration of your own practice

What is 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, March 2017

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 generates good outcomes

Table 1 *Rationale for integrating mental health care into primary care, as proposed by WHO and Wonca 2008*

What is integrated care?

- Bree Collaborative Standards
  - Founded 2011 by stakeholders in WA
  - Consortium of stakeholders "*to improve quality, health outcomes, and cost effectiveness of care in Washington State.*"

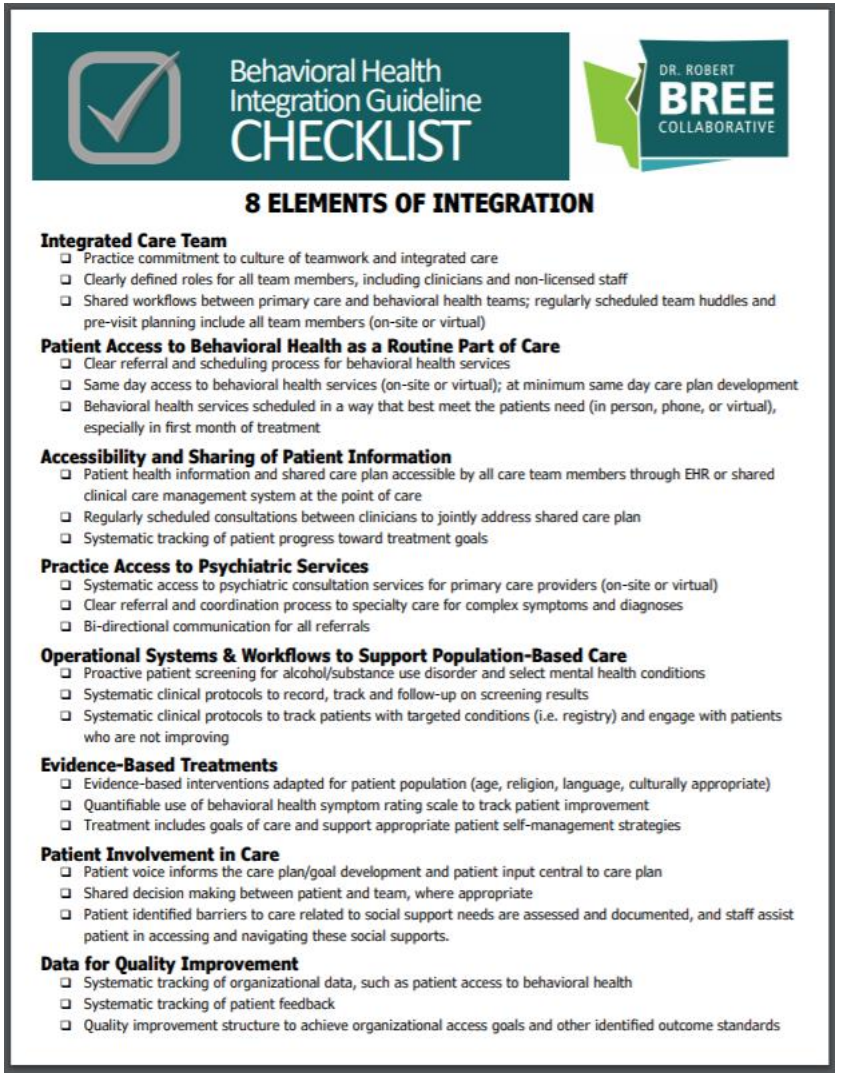
- Behavioral Health Integration Report (March 2017) and self-assessment tools

http://www.breecollaborative.org/topic-areas/previous-topics/behavioral-health/

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

Bree Collaborative Core Measures

Core Process Measures
Behavioral Health Integration Guideline
Primary Care Setting

Measure	Description
Integrated Care Team	Frequency of Integrated Care Team huddles (onsite or remotely).
Screening Tools	Percentage of patients screened for behavioral health conditions using a validated screening tool.
Access to BH services	Percentage of patients with identified behavioral health needs that receive warm hand-off or same day referral to behavioral health services (if warm-hand-off not available).
Shared Care Plan	Percentage of patients with identified behavioral health needs that have a shared care plan through EHR or other shared clinical care management system.

http://www.breecollaborative.org/wp-content/uploads/BHI-Core-Measures.pdf

How does integrated care work?

- Foundational processes:
  - Not just workforce change
  - Systems change and practice evaluation are keys
- *"Integration is a fully articulated customer-oriented continuous quality improvement process"* (SAMHSA-CHIS)

Spectrum of integrated care

- 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

Range of integrated care models

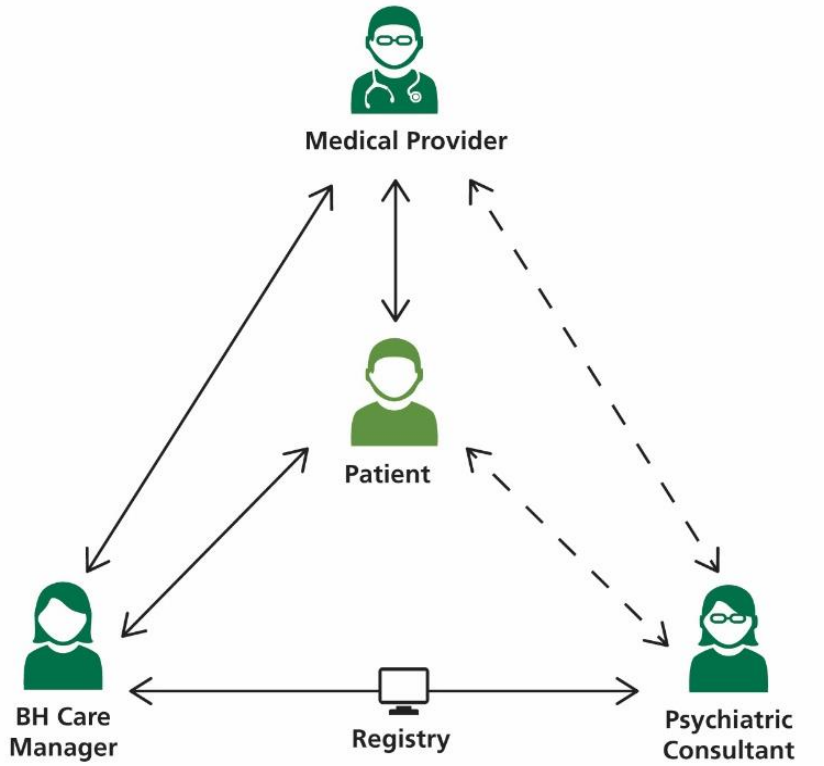
Examples

- Co-located
- Primary Care Behavioral Health (PCBH)
- Collaborative Care (AIMS model)
- Task Shifting

Considerations

- Complementary, not in competition
- Pros/Cons
- Implementation should consider clinic and population needs

Collaborative Care



FIDELITY TO CORE

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care

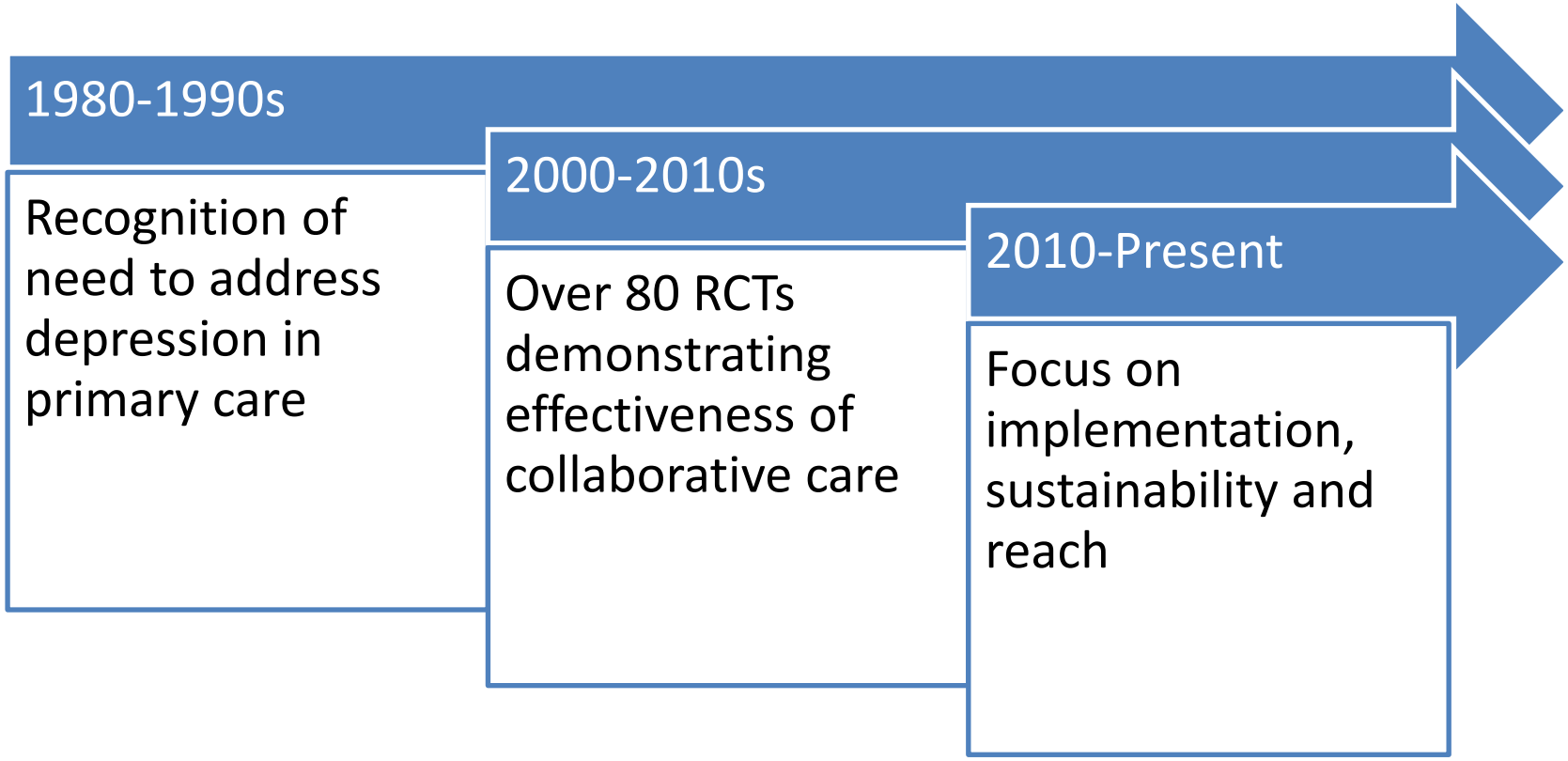
- Accountable Care

Collaborative care evidence

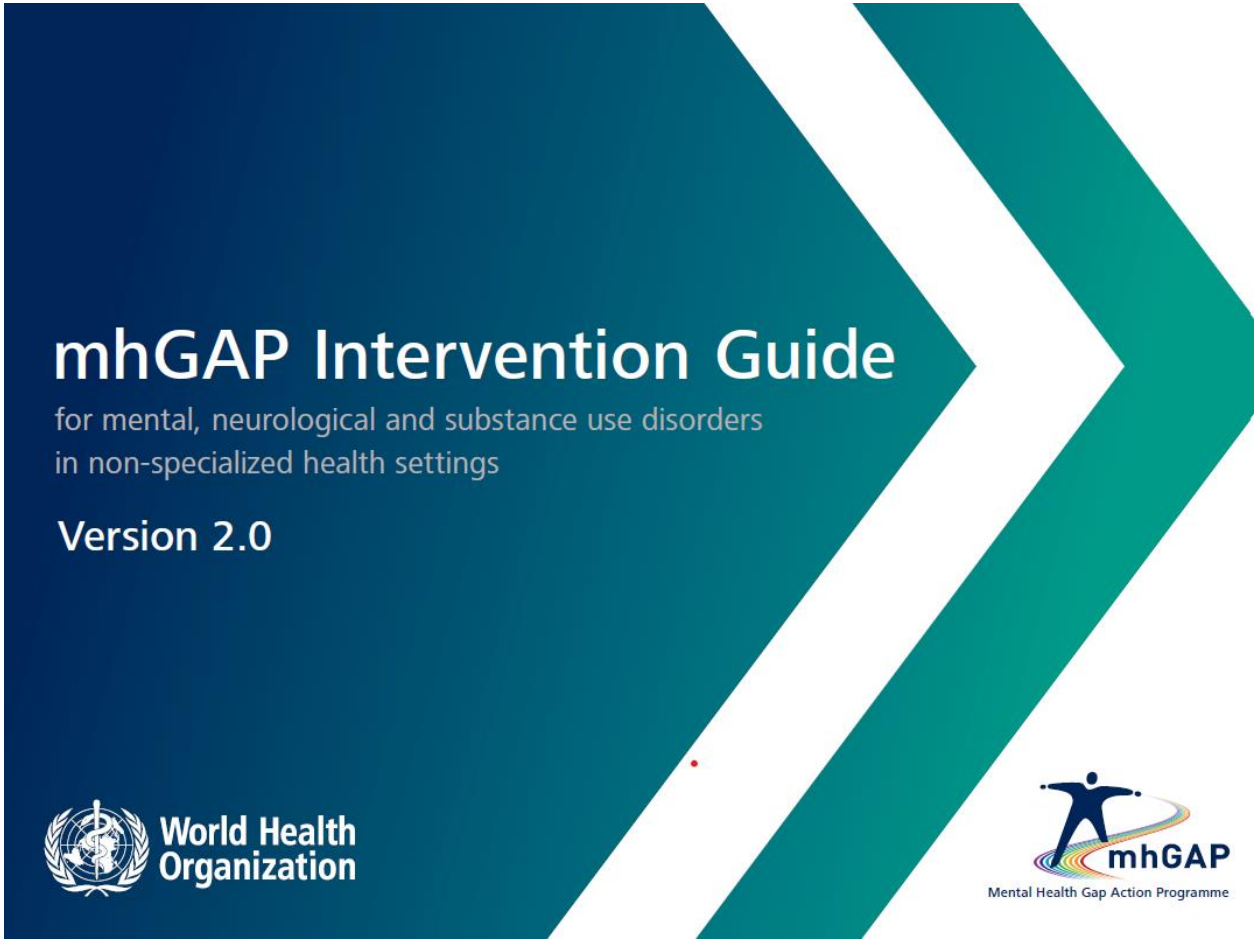
- Now over 80 Randomized Controlled Trials (RCTs)
  - Cochrane meta analysis of Collaborative Care (CC) for depression in primary care (US and Europe)
  - Consistently more effective than usual care

- Advancing Integrated Mental Health Solutions (AIMS) Center
  - Dissemination and implementation center for collaborative care
  - Resource library and other tools
  - https://aims.uw.edu/

History and future of CoCM



WHO mhGAP Program



https://www.who.int/teams/mental-health-and-substance-use/mental-health-gap-action-programme/evidence-centre

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
- AIMS Center Implementation Guide and Resource Library

Where does your practice fall on the spectrum?

- Tell us your name, where you're working and what your current behavioral health practice looks like

Goals for learning collaborative

- What are you hoping to gain or learn from this series?
- What topics would you like to see?
- Any speakers you would like to hear from?

Upcoming topics

Month	Topic/Activity
January 26 12:00 – 1:00 pm	Integrated Care Models: Where does my practice fall on the integrated care spectrum?
February 23 12:00 – 1:00 pm	Working with Behavioral Health Care Managers: How can I communicate effectively with BHCMs?
March 23 12:00 – 1:00 pm	Working in Primary Care ettings: How can I communicate effectively with PCPs?
April 27 12:00 – 1:00 pm	Implementing Integrated Care: How do I help my organization build and sustain a successful program?
May 25 12:00 – 1:00 pm	Best Systematic Caseload Review Practices: How can I most effectively use my time?
June 22 12:00 – 1:00 pm	Population Health Management: How can I start thinking of patient care from a systems perspective?

UW Resources

- AIMS Center
- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666

UNIVERSITY of WASHINGTON

PSYCHIATRY CONSULTATION LINE (PCL)
877-WA-PSYCH

The **Psychiatry Consultation Line** helps eligible providers in WA who want advice regarding adult patients (18+) with mental health and/or substance abuse disorders.

How does it work?
- Call 877-WA-PSYCH (877-927-7924)*
- Speak briefly with a UW health navigator
- Consult with a UW psychiatrist
- Receive written documentation of recommendations

Who can call?
Prescribing providers in Washington State from:
- Primary care clinics
- Community hospitals & EDs
- County and municipal correctional facilities

Why would I call?
You have questions about:
- Medications
- Dosing for medication-assisted treatment for opioids
- Differential diagnosis

Caveats – PCL Psychiatrists cannot
- Speak directly to patients
- Review written records
- Manage psychiatric emergencies
- Satisfy Single Bed Certification requirements

Available Monday-Friday 8am-5pm (excluding holidays)

Questions? Visit **www.uwpsychiatry.org/pcl** or email PCLWA@uw.edu

**Providers with patients under 18 will be directed to the Partnership Access Line (PAL);*
Providers caring for pregnant or new moms will be directed to the PAL for Moms line

Integrated Care Training Program

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
- WHO: Integrated Care Models Overview:
  - https://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf

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