Integrated Care: How to Move from "We Wish" to "We Do"

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Objectives

- Describe the rationale for integrating care
- Learn to apply the six-level framework for successful health care integration
- Understand the **‘Integrated Practice Assessment Tool’ (IPAT)** and its application
- Review common challenges that occur when integrating care

Integrated Primary Care

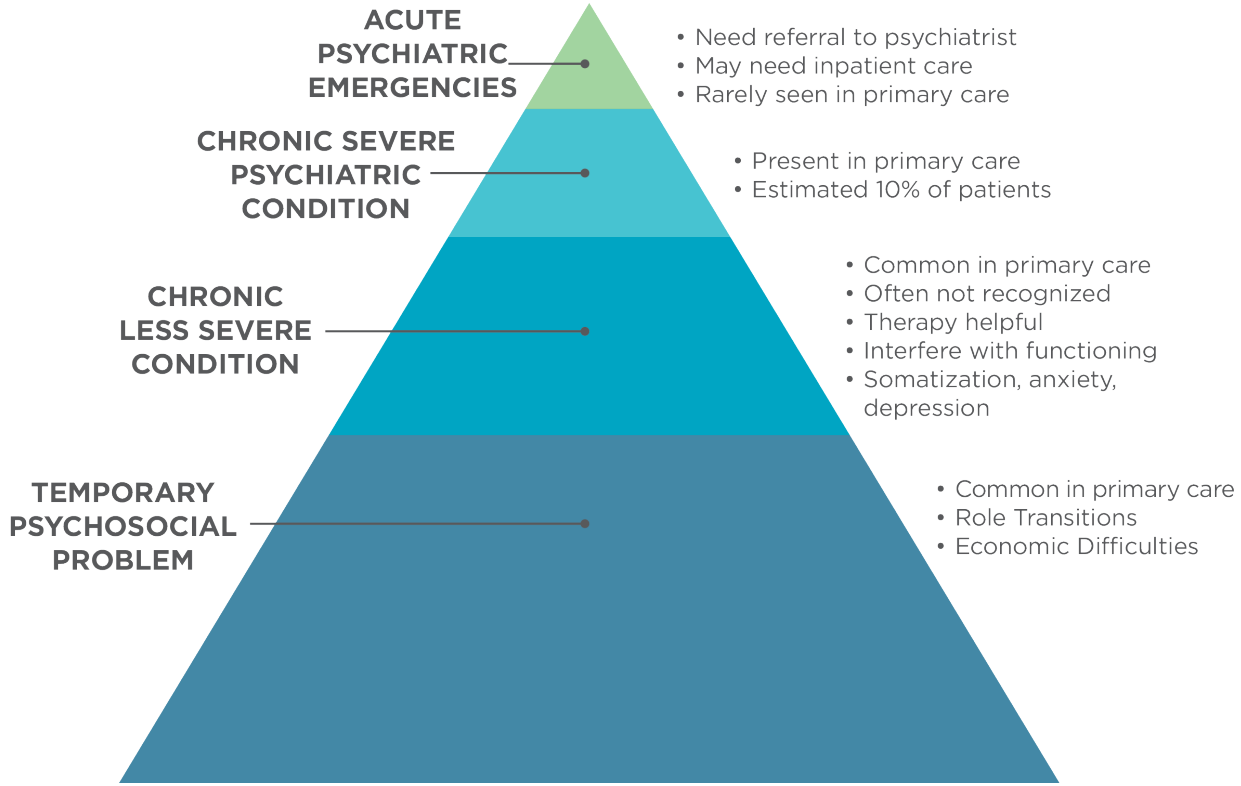
- PCPs deliver over half of all mental health treatment
- Most psychotropic medications are prescribed by PCPs
- Most people receiving referrals to specialty mental health do not follow through with the referrals

25% OF PRIMARY CARE PATIENTS **HAVE DIAGNOSABLE MENTAL DISORDERS**

50 to 70% OF A PCP'S NORMAL CASELOAD CONSISTS OF PATIENTS WHOSE **MEDICAL AILMENTS ARE PSYCHOLOGICALLY RELATED**

40% to 60% OF PEOPLE WHO COMPLETE SUICIDE **HAVE SEEN A PCP IN THE PRECEDING MONTH**

Integrated Primary Care



Integration for Individuals with SMI

- On average, individuals with SMI die 25 years earlier than those without
- The majority of deaths are related to co-occurring medical illness, mainly cardiovascular disease, respiratory illness and cancer
- People with SMI are less likely to receive routine cancer screening, standard levels of diabetes care, surgical interventions for cardiovascular disease, treatment for arthritis, and post-stroke treatment

1/4 OF ALL NON-INSTITUTIONALIZED U.S. CIVILIAN ADULTS, **ARE AFFECTED BY MENTAL ILLNESS**

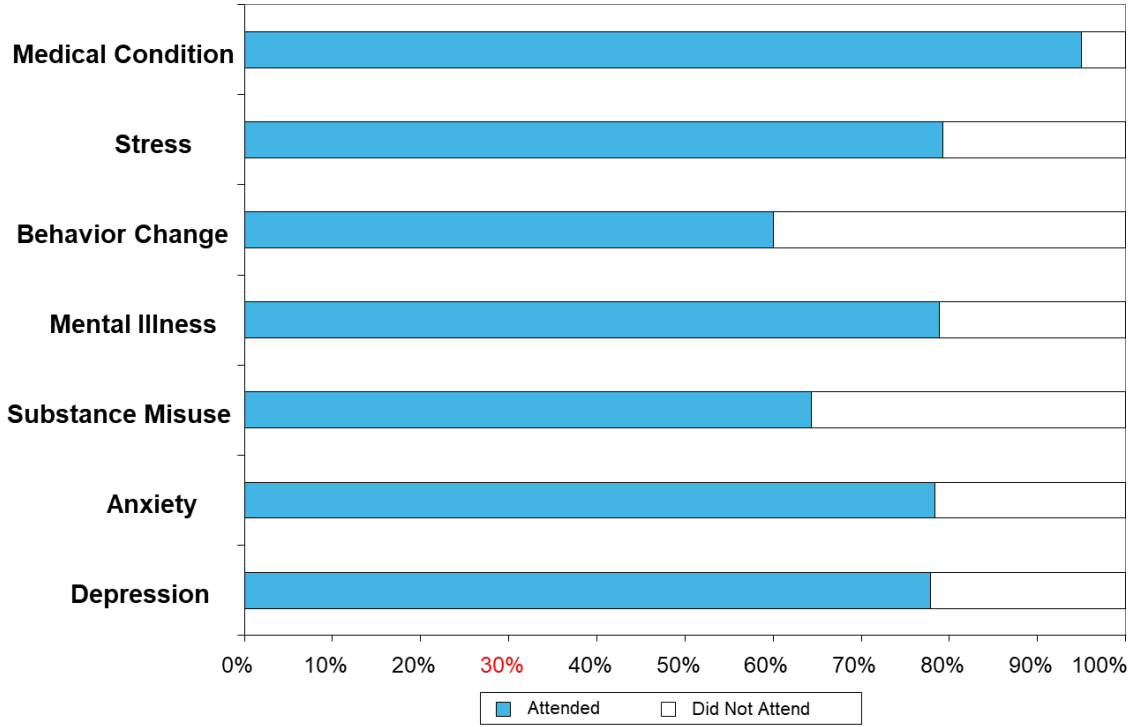
4-5% ARE CLASSIFIED AS **HAVING A SEVERE MENTAL ILLNESS**

PEOPLE WITH PSYCHIATRIC DIAGNOSES ARE **11x** **MORE LIKELY TO DIE AFTER ACUTE HEART DISEASE** THAN THOSE WITHOUT

Integrated Care Evidence

- Facilitates collaborative treatment
- Improves PCP ability to address behavioral health needs
- Results in cost reductions
- Improves overall health
- Improves patient experience
- Improvements in indicators for diabetes, hypertension, and high cholesterol
- Results in higher treatment initiation rates than referrals to specialty behavioral healthcare
- Improve patient and provider satisfaction

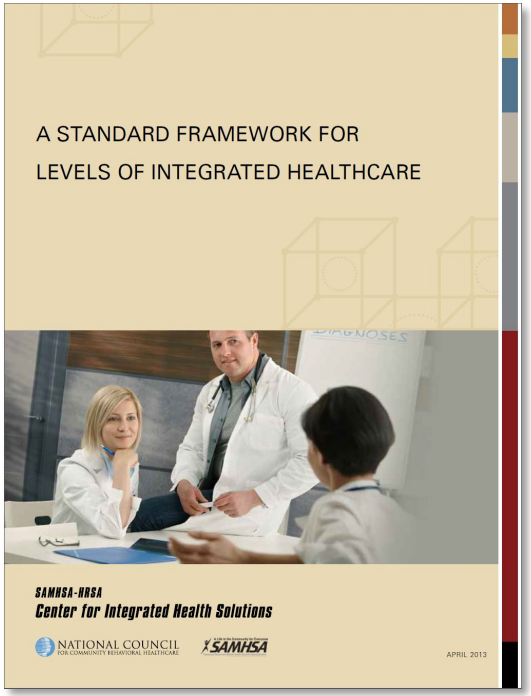
Co-Location Improves BH treatment Initiation



Auxier, Runyan, Mullin, Mendenhall, Kessler, & Young (2012). Behavioral Health Referrals and Treatment Initiation Rates in Integrated Primary Care: A Collaborative Care Research Network Study. Journal of Translational Behavioral Medicine.

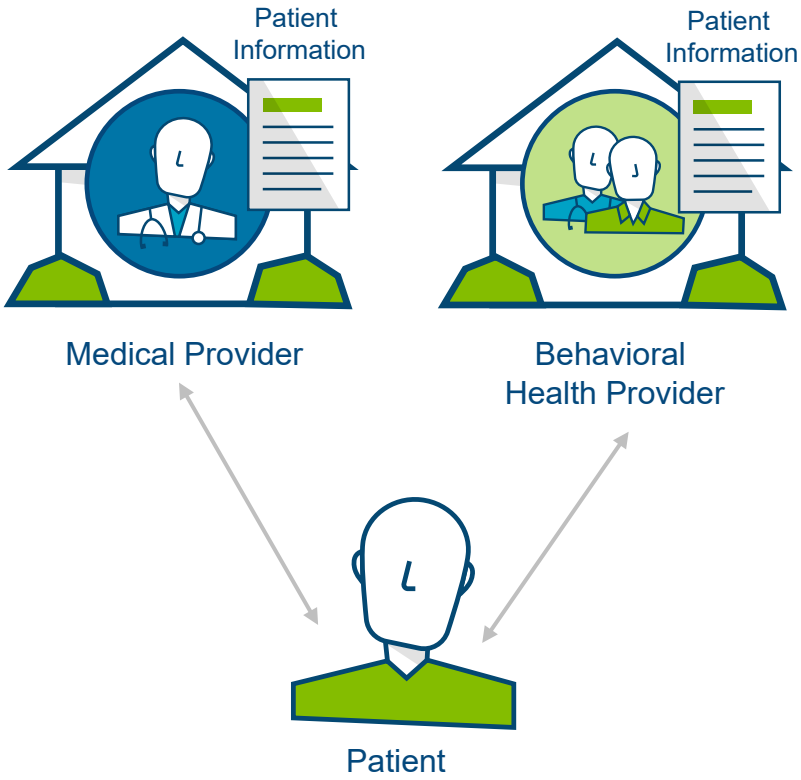
The Standard Framework

Coordinated Care		Co-Located Care		Integrated Care	
1	2	3	4	5	6
Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration Onsite	Close Collaboration with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed /Merged Practice



http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

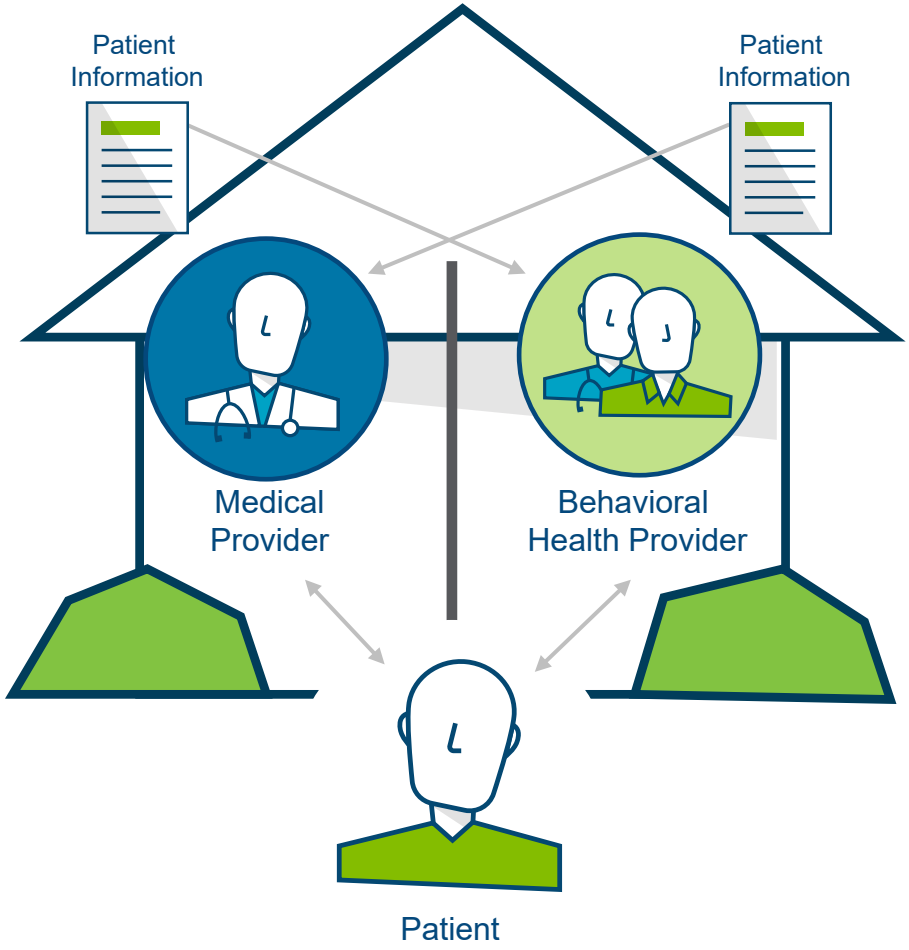
Coordinated Care



- Bi-directional exchange of information, usually written or electronic
- Protocols or health IT may be in place
- Level 1:
  occasional information sharing
- Level 2:
  routine information sharing

Co-Located Care

- Physical or virtual co-location
- Care delivered separately
- Separate documentation
- Few or no standard protocols for integration

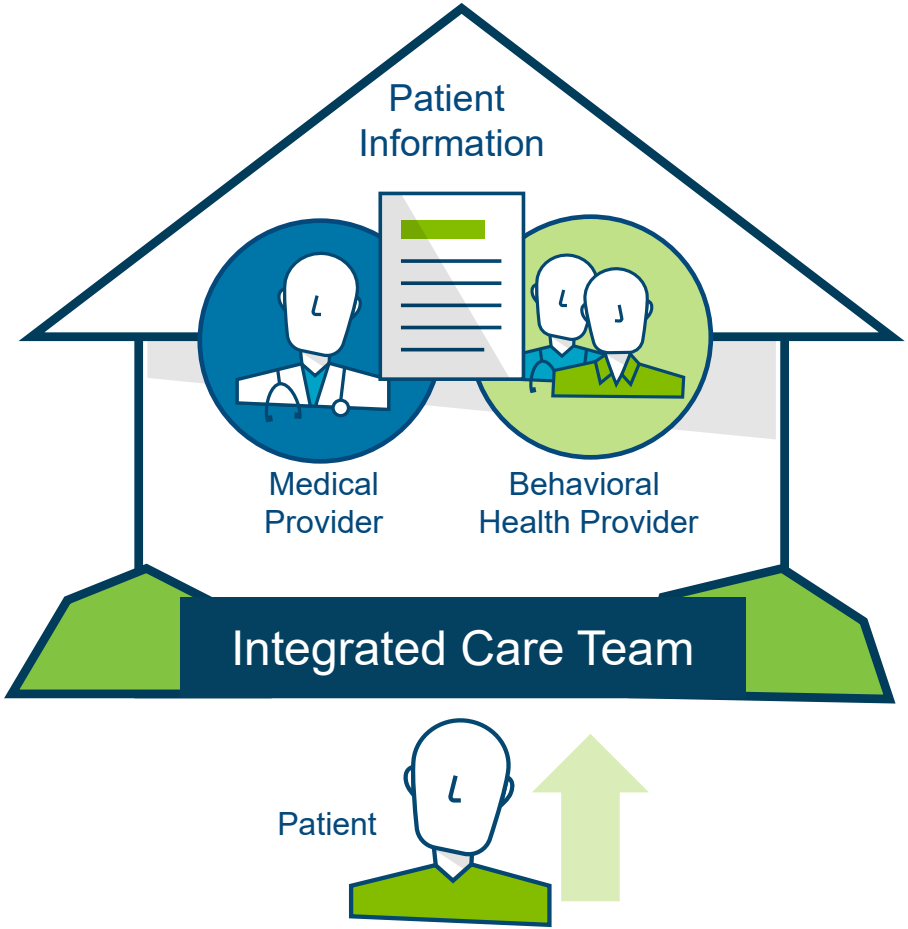


Integrated Care

- Team based approach
- Virtual or actual co-location

  Attention to psychiatric as well as health and behavior change using:

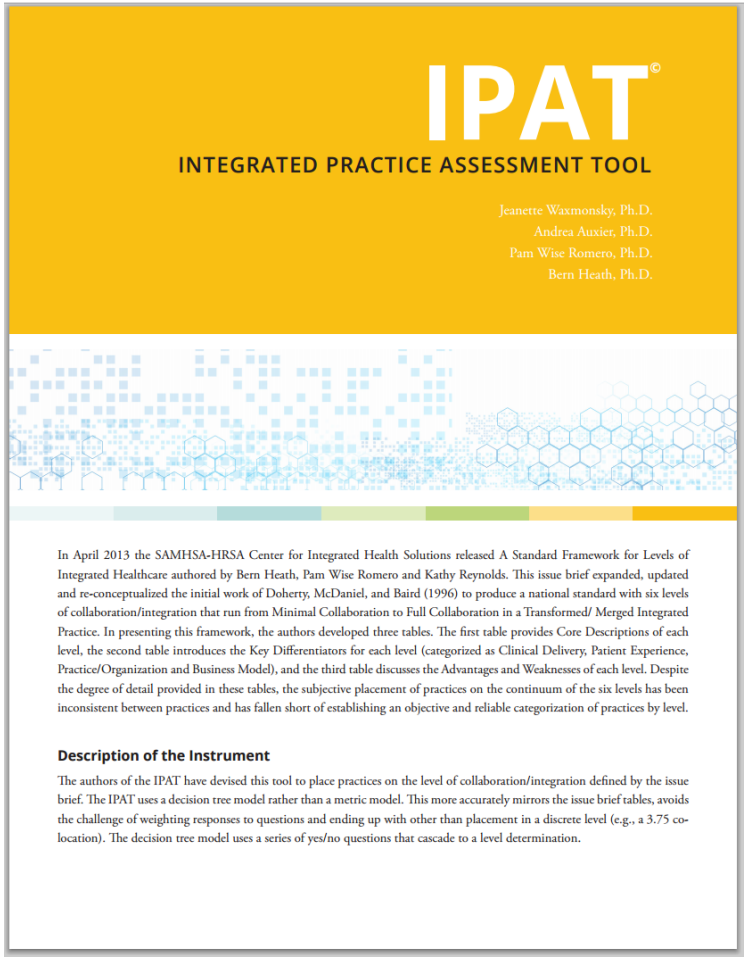
  - Real time interventions
  - Screening protocols
  - Shared documentation
  - Open access to records



The IPAT

- Quick and easy
- Practical vs. academic
- Bidirectional

Available at: https://www.cpaawa.org/wp-content/uploads/2017/11/IPAT_v_2.0_FINAL.pdf



IPAT©

INTEGRATED PRACTICE ASSESSMENT TOOL

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Bern Heath, Ph.D.

In April 2013 the SAMHSA-HRSA Center for Integrated Health Solutions released A Standard Framework for Levels of Integrated Healthcare authored by Bern Heath, Pam Wise Romero and Kathy Reynolds. This issue brief expanded, updated and re-conceptualized the initial work of Doherty, McDaniel, and Baird (1996) to produce a national standard with six levels of collaboration/integration that run from Minimal Collaboration to Full Collaboration in a Transformed/ Merged Integrated Practice. In presenting this framework, the authors developed three tables. The first table provides Core Descriptions of each level, the second table introduces the Key Differentiators for each level (categorized as Clinical Delivery, Patient Experience, Practice/Organization and Business Model), and the third table discusses the Advantages and Weaknesses of each level. Despite the degree of detail provided in these tables, the subjective placement of practices on the continuum of the six levels has been inconsistent between practices and has fallen short of establishing an objective and reliable categorization of practices by level.

Description of the Instrument

The authors of the IPAT have devised this tool to place practices on the level of collaboration/integration defined by the issue brief. The IPAT uses a decision tree model rather than a metric model. This more accurately mirrors the issue brief tables, avoids the challenge of weighting responses to questions and ending up with other than placement in a discrete level (e.g., a 3.75 co-location). The decision tree model uses a series of yes/no questions that cascade to a level determination.

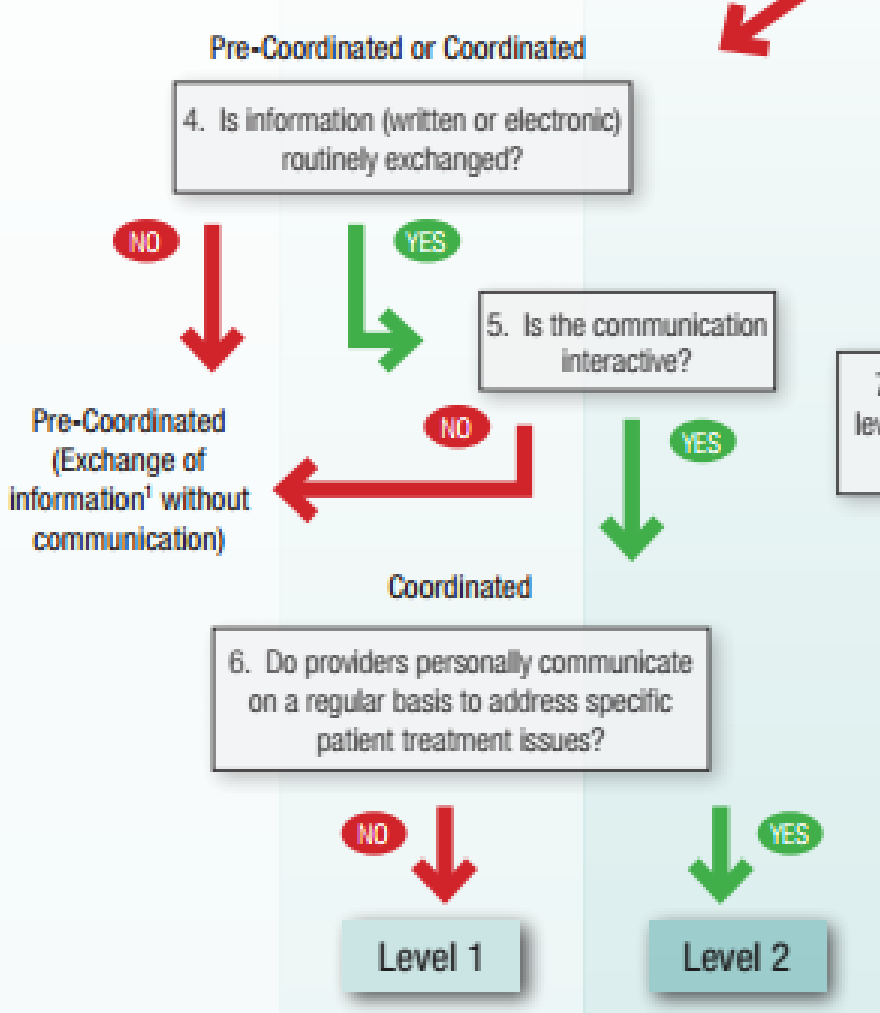
Integration Across the Continuum

Pre-coordinated	Coordinated	Co-Located	Integrated
Medical and behavioral health care are provided in different settings, with little, if any, communication between providers regarding shared patients; limited, if any, protocols for sharing information; information technology to support registries or patient information exchange do not exist or are not utilized.	P2P communication about shared patients across agencies; some protocols and technology for sharing information exist and are routinely followed.	Behavioral and medical providers delivering services in the same physical facility; medical and behavioral care remain mostly divided; documentation of services often occurs in separate records; few-if any standard protocols for integrated service delivery exist.	Behavioral and medical providers practicing in a team-based fashion with attention to psychiatric conditions as well as health and behavior change, using real-time interventions, screening protocols, shared documentation, and open access to records.

We added a level

Yes, No, Maybe?

- “Is this ‘partially’, ‘mostly’ or ‘completely’ a yes or a no response?”
- A “yes” response is recorded only if it is completely a yes response; anything less must be considered a “no”
- 8 questions in the full decision tree; responses to no more than 4 questions will determine the level of integration
- Best completed collaboratively by two or more persons



Why Measure Integration?

- Practice Transformation
  - Establish baseline and monitor performance over time
- Determine network readiness for integration
- Conduct comparative analysis
- Assess the association between integration and selected clinical, cost, or utilization outcomes
- Establish thresholds for differential payment structures

State	Description
Colorado	Medicaid BHO Carve-Out State Innovation Model
Connecticut	Medicaid Health Homes
Florida	Medicaid SMI
Idaho	Division of Behavioral Health, Department of Health and Welfare
Louisiana	Department of Health, Office of Behavioral Health (AmerihealthCaritas)
Massachusetts	MassHealth (Medicaid)
Michigan	Michigan Health Endowment Fund
Minnesota	Mayo Clinic HRSA Grant – Integrated Behavioral Health Training in Primary Care
New York	HARPS (Medicaid SMI/SUD)
Washington	United Healthcare Practice Transformation Guide for Integrated Managed Care
SAMHSA	PCBHI Minority Aids Initiative Project LAUNCH Integrated Primary Care Learning Collaborative

IPAT FAQs

- **What is IPAT©?** is a questionnaire used to determine how integrated a clinical practice is. It builds of the SAMHSA-HRSA standard framework for Levels of Integrated Healthcare.
- **How does IPAT© work?** IPAT© asks a series of yes/no questions using a decision-tree model to arrive at the practice's current level.
- **Do I have to provide PHI?** No. IPAT© does not inquire about patient-level information.
- **Do I have to pay to use IPAT©?** No. IPAT© is in the public domain and is provided free of charge. IPAT©
- **Will work only in primary care settings?** No. IPAT© can be used in behavioral health or medical settings.
- **Who should complete the IPAT©?** IPAT© can be completed by medical provider, a behavioral health provider, or a practice manager. Ideally, several members of the care team would collaborate on a joint response.
- **What if I have multiple clinics in my setting? Do I complete just one IPAT©?** No. Because IPAT© is intended to assess clinical operations, a different IPAT© should be completed for each clinic.

How Integrated Am I?

- A part-time social worker in a primary care clinic receives warm-handoffs and provides treatment for mental illness, but does not attend meetings with the patient's medical provider
- A mental health center hires a psychiatric nurse practitioner
- A psychiatrist provides P2P consultation to a PCP via televideo
- Behavioral health practitioners work alongside primary care practitioners – they routinely share information, but there are no standardized protocols

Challenges

Clinical	Operational	Financial	Ethical/Legal
Determining what to handle in-house vs. referring out	Workflow challenges	Siloed funding streams; variable state & federal regulations	Who is ultimately responsible for the patient?
Provider training	Service-delivery models vary greatly	Not all billing codes “open” everywhere	Confidentiality
Provider temperament	Determining what kind of data to capture and what to do with it once you have it	Co-location is more viable than integration	Confusion regarding CFR 42 & HIPAA
PCP vs. BHP roles and responsibilities are not always clear	Many EHRs rely on custom templates	Restrictions on allowed provider types vary by payer	
	Telehealth		

Tips & Lessons Learned

- Integration is a leap of faith!
- Behavioral health is for some people, integrated care is for ALL people
- Take the time to hire the right provider for the job
- Behavioral Health Consultants or Behavioral Health Providers?
  - Setting expectations for the role
- Payment reform can facilitate integration but will not, in and of itself, achieve it
  - Full integration requires full practice transformation
  - Full practice transformation is hard, and takes time
- Integration is not one size fits all

Resources to Learn about Integrated Care

- Agency for Healthcare Research and Quality
  - https://integrationacademy.ahrq.gov/about/integrated-behavioral-health
- Health Resource and Services Administration (HRSA) Integrated Behavioral Health Resource Library
  - https://www.hrsa.gov/behavioral-health/library
- The SAMHSA-HRSA Center for Integrated Health Solutions
  - https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Website-Resources.pdf?daf=375ateTbd56
- Integrated Care and the Collaborative Care Model – American Psychiatric Association
  - https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care
- Collaborative Family Healthcare Association Webinars, Lectures, and Videos
  - https://www.cfha.net/page/PCBHLecturesVideos
- Advancing Integrated Mental Health Solutions (AIMS Center)
  - https://aims.uw.edu/
- Project ECHO at the University of New Mexico
  - https://hsc.unm.edu/echo/