Overview of Integrated Care Models, Structures, and Processes

Kayla Baker: Welcome to the Behavioral Health, Substance Use Disorder, Integration, Technical Assistance Webinar Overview of Integrated Care Models, Structures, and Processes Supporting Effective Primary Care and Behavioral Health Integration. Before we begin, there are a few housekeeping notes to share. This session is being recorded. Participants have entered in a listen-only mode, cameras are off, and mics are muted.

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Joseph Hyde: Good afternoon, folks. Joe Hyde here. I'll give you a little bit about myself. Some of you may know me from times past. I have been connected to this initiative. I'm now entering my fifth year as a trainer subject person. Previously, I worked as a behavioral health consultant in a community health center, and I have been a practicing behavioral health provider for more than 30 years. That's a bit about me. I am here in coastal Rhode Island where there is torrential rain happening and the roads are flooding. Welcome and thank you for being here. Thank you for your interest.

Let me talk a little bit about what the objectives are. I think we want to orient folks to the models and strategies of integrated care and some of their common elements around team-based care, collaborative care planning, and that there are enhancements to the roles of staff, both behavioral health, primary care, and nursing. Then we want to talk about the three most commonly described models of integrated care in that there is the patient-centered medical home, which also has an accreditation or certification that goes along with it.

The primary care behavioral health integration model, which comes out of the West Coast, a lot of the writing around that came out of Mountain View, and the health center that's connected to those guys, and then the collaborative care model, which comes out of the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center. Those are the models we're going to talk about. Some permutation of those is what most health centers step into when they're looking at integration. I'll try it again. There it goes.

Our agenda here today, part of it, is we want to start off talking about the why questions, like why integrate care in community health centers. We'll talk some about

the research models of Patient-Centered Medical Home (PCMH), Primary Care Behavioral Health (PCBH), and the Collaborative Care (CoCM) models. The important thing connected to that is to understand context and contextualism, which is a really powerful piece of this because these models are basically, blueprints, if you will, for what integrated care might look like.

Any of you who've ever either rehabbed a house or built one, you know that you may have this plan, but it has to make sense. For health centers, it has to make sense within the organization, within the staff that you have, with the community that you serve, and the patients that you serve, and the funding structure. That's what context is about, as we're defining it here. That's what our agenda is looking like.

Now we're going to do a quick polling question so that we have a better idea about who's in the room with us today. Please answer it, because that helps me then to shift some of my responses to what you've got here.

[pause 00:05:01]

We're up to about two-thirds at this point. Keep going. We'll keep this open for another bit. This is really just helpful for us, and for me, really, about who's showing up here so that I can frame my content to be most relevant for you. [silence] In fact, we've quieted down there, Kayla, so why don't we drop the poll and share the results?

[pause 00:05:44]

We've got a good number of administrative folks, a reasonable number of behavioral health folks, I think a small number of more medical providers, and we've got a community health one. That's a nice mix. I think that that's relevant to what we're talking about here today. Good. Thank you so much. There are some common elements to integrated care. First thing is that integrated care is team-based. It is a team that includes primary care, behavioral health, and can include other people too.

Increasingly we're seeing peers, we're seeing community health workers, pharmacy, all kinds of folks showing up, but it's really a team-based care, supporting specific populations that you're serving. That the team works together to support patients and their families, and being there as an asset to the community. That we look at using more of a systematic and a cost-effective approach.

Cost-effective, though, is an interesting term, because with certain patients, particularly patients with more complex comorbid health conditions, it might be a smidge more expensive in terms of what your Medicaid or Medicare is paying. However, the evidence is pretty irrefutable that if these patients are being managed in a team-based approach, it's keeping them out of hospitals and out of emergency rooms. That overall is reducing and more cost-effective, which is why many states now are really championing integrated care, particularly for the patients with complex illnesses.

It's patient-centered, and it's oftentimes defined for a specific population. I got involved with the health center really around two populations. One, there was a really large industrial plant not far from the health center. A lot of people got injured. It was

10,000 employees there. A lot of persons ended up with chronic pain conditions, went back to work too early, became dependent on painkillers, and showed up with us. A defined population. The other population that we did a lot of work with, and a lot of health centers do work with, were these patients who ended up with diabetes and comorbid depression. There was that.

Then the other is to provide preventative care for all patients. Those of you who may be familiar with the term screening, brief intervention, and referral to treatment, that oftentimes is the model that's used to not only screen for alcohol or other drugs but also to screen for depression, anxiety, other kinds of health behaviors where you can intervene earlier, because the evidence is irrefutable. The earlier you intervene, the better are the clinical outcomes.

Integrated care addresses both mental health and substance use conditions, health behaviors which can contribute to the chronic medical condition. Health behaviors are things like diet, exercise, sleep hygiene, stress management, those kinds of things, and how to deal with stressors and crises, and all of these kinds of stress-related symptoms that really contribute to just ineffective healthcare utilization. That's part of it, where it's expanded beyond a more strictly defined medical model.

Why integrated care for health centers? I think you probably know, but health centers are the healthcare safety net for the United States. Millions of US residents get their care through our health centers. They're all over. If I remember correctly, there's what, 11,000 health centers that are recognized by Health Resources and Services Administration (HRSA), a number of rural health centers, and I forget, there's 40, 50,000 sites. They really are our safety net.

The populations you serve, they are at higher risk of health and mental health disorders, because of many of the folks who are served in health centers have adverse social and economic, and environmental factors. It serves a higher percentage of our racial, ethnic, class, gender despairs. Those folks tend to show up in our health centers. We know. This is not made up by Joe Hyde, this is straight out of the World Health Organization, that the disadvantage of these folks often begins to birth, and it accumulates across the lifetime.

These people who have experienced these kinds of social inequalities are causally linked to higher risks for mental disorders. We know that integrated care better serves patients with comorbid conditions. Again, I've looked at the Uniform Data System (UDS) measures on the HRSA website, that a majority of health center patients have at least one and oftentimes more than one chronic health condition. That's why integrated care makes sense.

Now we're going to talk about the three models that you hear talked about the most. In the models of integrated care, first of all, we're going to talk about collaborative care model. This came originally out of the AIMS Center. The collaborative care model, you hear the patient, primary care, behavioral health, and psychiatry, and they're usually in there as a care manager at the center of this coordinating all of this.

The care manager originally at AIMS, I think it was like a social worker. Some states I know are using nurses as care managers. It was really targeting persons with complex comorbid condition. The collaborative care model often uses patient

registries within the electronic health record to really align and monitor care because these people have complex needs. That it really helps them keep the team organized and that they use a common care plan.

Some of the elements of the collaborative care is that they collaborate and they share a common plan. It oftentimes is really targeting a defined population. As I said, they commonly use electronic health record. From my experience providing consultation and training, a lot of places will start with, just because it's so common, patients with diabetes and comorbid health behaviors, and comorbid depression. That they'll define that population based on glycated hemoglobin (A1Cs) and other symptoms. They'll keep them all within a registry so that care can be monitored more carefully.

Measurement-based treatment for some folks, particularly behavioral health folks, seems new, but it really isn't. What it really means is that care is monitored and outcomes are measured on a regular basis. In the small psychotherapy practice that I work in up here in Rhode Island, I see a number of people who are depressed who've been started on an selective serotonin reuptake inhibitors (SSRI). At baseline we do a Patient Health Questionnaire (PHQ) and if their number was 21, which demonstrates major depression.

At six weeks, we might deliver it again and hopefully, we're seeing that 21 go down a bit. At 12 weeks, we want to see measurable improvement. That's what measurement-based is. We are periodically monitoring to measure improvement. If they aren't getting better, then we need to re-look at that plan. That's the important piece of measurement-based care. It's regarding specific targets.

Use of evidence-based care? Absolutely, both in medicine and in behavioral health. The issue that we've found with behavioral health is that a lot of behavioral health providers have been trained as generalists. A fair amount of the work that we've done over the years has been training people in things like behavioral activation, motivational interviewing, and targeted cognitive behavioral therapy skills. That we are accountable in the collaborative care model for the quality of care delivered and for outcome. That's how that model works.

Then this is the PCMH home, which is similar to this. PCMH is a certification, I think all of you know, you can get through the Joint Commission. Again, it primarily is looking at a chronic care population. One of the things that I like about PCMH is that it does begin to enter into it some conversations about cultural relevance, looking at the culture of where people come from, their values, and their preference, which I think is a nice piece that they've added to it.

We did training in Texas, and this largely Hispanic group of medical assistants talked about in their families, diabetes was genetic. It wasn't dietary. That was their understanding of what diabetes was. It was just in your genes. Which for many folks is not true. That's the primary care model.

Again, co-location of behavioral health and primary care, shared appointment systems, same-day practices, or preferreds. That's where contextual stuff comes in. That there is bidirectional access between primary care and behavioral health. It's team-based care, population-based care. It looks at building out clinical pathways,

often through registries. There is also an expectation of performance improvement team, like plan-do-study-act (PDSA) work. If something isn't working, then that's grist for the mill to be improved.

PCBH, which is probably the most commonly understood, commonly used. Again, team-based care, it involves the behavioral health consultant as a core member of the team. The behavioral health (BH) role is more significantly defined in terms of triage, treat, and manage primary care complexities and health behaviors. It really is based upon a philosophy of population-based care.

Key member, the BH role is significantly different from conventional psychotherapy. Very few people are trained in brief consultation. That's been a lot of the work we've done over the last years, where services can be delivered in 15 to 30 minutes as opposed to the conventional 60-minute hour behind a closed door. PCBH also embraces prevention and early intervention. Most commonly, what you see is screening, brief intervention and referral to treatment (SBIRT), that universal screening, brief intervention, and treatment or service engagement, or risk reduction. It provides or can provide the treatment for behavioral health conditions.

One of the cool things, I think, about the BHC model is that it can really address health behaviors that impact physical and chronic health conditions so that a behavioral health consultant can be working with somebody about diet and exercise. That's where things like behavioral activation strategies come very much into play, and it uses clinical pathways to organize care. That's the primary care behavioral health integration. Too many words here. Sorry about that.

Then here's where I want to talk a little bit more granularly because there are challenges to all of these. That's why not everybody's doing them. First off, at startup, there are costs for implementation. You might have to change your electronic health record. You might have to re-look at your personnel, those things. There are workforce shortages. Specifically, there are some workforce shortages also in evidence-based intervention. We've had the pleasure now to work with a couple of behavioral health graduate schools in beginning to train providers how to work successfully in community health centers.

Most behavioral health folks and other folks, primary care as well, there are time limitations. I was trained in several different evidence-based psychosocial evaluations. One of them took four hours to do, and at most I've got a half an hour to do that. Evaluation and assessment become way more truncated. That people have limited knowledge around measurement-based care. There are billing restrictions. Probably the most troublesome one is that some states will not allow for medical and mental health visits to be billed in the same day.

The other thing that we all have to work with is that patients have stigma in terms of mental illness and substance use disorder, probably even worse than mental illness, and receiving care. There is the collaborative care Medicaid billing code, but I think the last time we checked, it was only active in about 30 states. That's a bundle. It's just not a regular-- I would invite you, if you don't know, check with your state. If you want to do that, that's where you'd use your primary care association to be your advocate.

Then let's talk about what helps you to move forward. The first thing, and I'm glad that there's a lot of administrative folks here, leadership buy-in is essential. It supports building readiness and startup and building practice champions, and that they begin to put forward the messaging that this integration is part of their strategy for achieving population goals. They're willing to begin to leverage the strengths of the system to do that, and they will help us stay the course.

A lot of people say, "We can do this in 15 minutes." Many of you may have heard of Cherokee Health. They're pals of ours, and we've done a lot of work with them over the years. They've been working at it for 40 years so that you really have to have a longer-term goal. The other thing that's important in terms of leadership is that they really wanted to empower practice site champions.

Quick story, I was working with a system in New York a while back, and they were convening the team to work on integration. I was delighted to see, sitting around the table with their medical staff, with a couple of psychologists, a couple of social workers, a nurse practitioner, were two medical assistants. The chief medical officer looked around at everybody and said, "I have these women sitting here because they know workflow better than any of us ever will." Brilliant on his part, really.

Then getting started. Some of this latter stuff I'm talking about here comes from-- We had the opportunity years past to do learning sessions and focus groups with about 20 health centers. This is what they said was useful for them getting started. First off was they didn't want to be shocked, and that there are plenty of things to read, but it was really useful for them to connect with consultants or people who have real implementation experience.

A couple of times, we've had the opportunity to bring health center leadership with us to do a visit to another health center and just have the time to sit with their medical and behavioral health about their lessons learned in terms of making this work. In addition to content expertise, it's like, how do the people work together? What are the systems things we do? If we have to leverage political expertise around policy change, how do we do that? Early preparation is important. It matters. There are great books out there, but they're books. The real experience of real people is super important.

As I said, leadership support, setting realistic goals for yourself. You're not going to empty the river with a coffee cup in one week or one year. It takes a longer-term view, build implementation plans with action steps that make sense in terms of your organization and the community in which you live. You have to build out agreements internally and sometimes with partners as well. You need to continue to, as leaders, support readiness and startup and continue to support your practice champions. You got to have regular systems of communication.

One place that we worked with said, "Oh yes, we've got regular communication. We need it on a quarterly basis." I said, "No, that's it. You got to meet probably weekly to get this thing started, even if it's just a half an hour and maybe, but regular communication amongst the team who are making these changes is really essential." Ultimately, you got to build out protocols, got to use technology, build out a set of tools.

You have to use participatory decision-making and ongoing training, technical assistance, coaching, monitoring to support implementation. If you're building out and doing new practices like behavioral activation or motivational interviewing or cognitive behavioral therapy (CBT) skills training on the behavioral health side of the house, or if you're maybe stepping into starting to do things like buprenorphine for the treatment of opioid use disorder, some coaching is useful and fidelity to practice matter.

Then finally, not almost finally, evaluation is your friend. It can really monitor what's working, what's not, and being sensitive to the unique contextual conditions of the practice site, the population you serve, and you will need to do adaptations along the way. What got created in Seattle and Washington may not make a whole heck of a lot of sense if there's anybody here from Texas or South Carolina or Rhode Island or where, because those are different worlds, different payer systems, different populations. Adaptation is going to happen. As long as you stay true to the principles, it's part of it.

Remember, I think, if my memory serves me correct, this term was first coined by a colleague who I did some work with at Yale, a guy named David Thelin. He was the principal investigator for buprenorphine when it was going through its clinical trials. I've stolen this as my own. Something new is never done 100% right the first time. These new practices that you're wanting to implement, the skills are incomplete, and they will need to be shaped to be most functional in your setting. That they're fragile and they'll require leadership support, and they may face weird reactions from consumers and others in the setting. Coaching, supervising, and monitoring matters in support of fidelity and your success.

Remember, context matters. Context of site, population, community, they will influence your goals and objectives, the work within your systems, and recognizing, again, population, you will always have to do some adaptations for it to make sense in your system.

What I have for you here at the end is a roster of various and assorted references. Some of them are books, but a lot of them are portable document format (PDFs) or links to websites. I curated this that there is a useful resource for you. Now, let's hear about question and answers.

Kayla: As a reminder, if anyone has a question for Joe today, please submit that into the Q&A panel on your screen. Joe will pause for just a moment to see if questions queue.

Joseph: Okay. Folks, I will stick around for 15 minutes after this is over. If folks have additional questions, happy to do that. If there's a question that I or we can't answer for you right now, I promise you, we will get back.

Kayla: Wonderful. I will take us through these last few slides. As Joe mentioned, we will keep the session open for questions. Actually, before I do, a couple of questions did just come into the portal. Are there differences in patient outcomes across the three models of integrated care?

Joseph: All three of them demonstrate patient improvement. That I think probably the bigger issue that impacts patient care has to do with the context in which you live. The collaborative care model is really targeted for people with comorbid conditions. That's its place. It doesn't do so much in terms of preventative work. If you really look at primary and behavioral health care integration (PCBHI), the floor in which it operates is the collaborative care model. Both of them demonstrate. I could pull the research as one better than the other. I think it's not so much the model, it's the implementation in your practice site that matters. Is there another question there?

Kayla: We do have a couple more, but I'm going to go ahead and get us through the last couple of slides and then we'll go back to Q&A with regarding to our time. Access for more behavioral health, substance use disorder, integration technical assistance opportunities by emailing the team and scanning the quick response (QR) code to subscribe to HRSA's Bureau of Primary Healthcare listserv. A TA portal will be launching soon to house post and future event information.

Save the date and register for our next webinar. A Systems Approach to Sustainable Integrated Behavioral Health on January 28th at 1:00 PM Eastern. That continues conversation starting today on integrated behavioral health. You can scan the QR code or register via the link in the chat. Please share your feedback on today's session. You must complete the assessment if you plan to claim continuing education credits. We appreciate your time to tell us about your experience today. The assessment will automatically open when you close the meeting and is also in the chat. At this time, we now will move into our open Q&A portal.

Joseph: Want to drop the slides? There we go. Okay, you want to read me some of those Q&As?

Fathia Muridi: Yes, I can do that. The first question we have is, do you have any recommendations for consultants to help with setting up your program?

Joseph: What I would invite you to do-- Certainly you can scour the internet, you can talk to your primary care association, but you also have here through this initiative, your federal tax dollars are working for you and you can reach out to BHTA and we can reach back to you and do coaching and to really help tailor in support of your needs. That's your federal tax dollars at work.

Fathia: All right. The next question is, we're exploring behavioral care and behavioral health (BCBH), do you have resources for implementation guidance for this model?

Joseph: For BCBH? Yes. If you look in the references in this slide deck, which I think a PDF of that, this will be made available to you. There's a manual that came out of Mountain View that is a manual for implementing primary care behavioral health integration. It was one of the early architects of this model, Kirk Strassel, and I forget the woman's name, **[unintelligible 00:32:57]**

We've worked with Kirk in the past. They wrote this-- it's a guidance manual. That's there and it's useful. There's some other things that are useful there too that can help you along that way. That'll get you some information, but you also might want to take a look at colleagues either in your state or in a neighboring state that are already

doing it. As I said before, don't be shy, reach out and say hello and maybe even go visit them.

Fathia: All right. The last question I'm seeing here is, what is the name of the health centers you mentioned at the beginning of the presentation as examples for using these models?

Joseph: Probably the most famous of them all, which is doing their version of PCBHI is Cherokee. Then I'm drawing a blank on their name, but I know it's acronym in the top of my head, the big institution out of Connecticut. They do a distribution list called Community Health Center, Inc. (CHCI). Those are the ones that come to mind. Again, I would reach out to us and also reach out to your primary care association. That's what you're paying them to help you with that guidance.

Fathia: Those were the questions we have. If there's anybody else that has any questions that would like to input it in the Q&A, please do so. We'll just give it a couple of minutes. Joe, if you want to elaborate on something, please feel free to do so.

Joseph: Sure. For me, doing this, when I first walked into the health center, one of the medical providers walked up to me and said, "I know who you are. Why are you here?" Dr. Nash was her name. Then when I was leaving there to come work in Washington five years later, she walked up to me and said, "When you walked through the door, I had no idea how we would use it. I cannot imagine running this health center without a behavioral health consultant today." I say that because it takes time to change culture. That's one of the things that I remember related to that.

I know that issues related to opioid use disorder are really preeminent in the population right now, so is suicidality. That was part of how I was there, because I have to roll out the training of medical providers on opioid use disorder throughout the Northeast. Ended up training about 600 docs over a couple of years. What was interesting for me with this is that they were some of the easiest patients there. Because these people that now were like coming in out of the storm.

They were getting appropriate care, both psychosocial on my part, and appropriate medical care. That the bias that some of the staff were having, were the worries that like these people. It was really interesting for me to be there as part of it. The doc who I worked for really championed so that every health center in Rhode Island now prescribes medications for the treatment of opioid use this way. Fathia, it looks like there was another question popped up.

Fathia: Yes. The question is, when you hear the term interprofessional care, how does this relate or compare to integrated care?

Joseph: Interprofessional care is oftentimes an academic construct. You will also hear terms similar to that it means that counselors, social workers, nurses, medical providers, you're all part of the same team. It's this segregated systems that we were all trained in. Actually, I'm glad I did, but I say, when I was trained originally, I was trained-- My graduate supervisor was a psychoanalyst. I learned a lot of things about my mother and father. It didn't exactly translate to working in health centers.

We walk out of graduate schools with some base, but I think the whole push right now is that we are working transdisciplinary because that's the other term you'll hear as opposed to interprofessional that a lot of our work is transdisciplinary across medicine and behavioral health. At our company, we've been blessed for gosh, almost a decade now to write curriculum for medical schools around the psychosocial side of medicine, which has been a great thing for us to be involved. Any other questions, folks?

[silence]

As we're closing out today, I guess what I would like to say to you is thank you for being here, but also thank you for the work that you're doing. I'm sure that the patients that you serve are grateful that you show up every day and that your work matters, is, I guess, what I'm really wanting to say to you. You are an asset in the community and making your community a better place, it matters. Thank you. With that, I think we'll say good night or good afternoon.

Kayla: Thank you all so much for your attendance. This concludes today's webinar, and you may now disconnect.