Driving Integrated Health at Your Organization: Quality Improvement and Foundational Factors that Lead to Success

PRIMARY CARE DEVELOPMENT CORPORATION

CoE Center of Excellence for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

Today's Moderator

Andrew Philip, PhD
Clinical Lead & Senior Director of Partnerships
Primary Care Development Corporation
New York, NY

About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Integration at Work

This year we will be covering critical concepts to support your practice of integrated care such as:

- Integration models
- Quality improvement
- Funding and relationship development
- Behavioral health screenings for primary care
- Primary care considerations for behavioral health

Presenters

Amy G. Breyer, LCSW, CPC-A
Senior Program Manager

Deborah Johnson Ingram, MPH
Senior Director

Maia Bhirud Morse, MPH, CPC
Senior Program Manager

Audience Demographics

Do you work in a:

- Primary care setting
- Behavioral health setting
- Integrated care setting

Please rate your current skills and comfort with applying quality improvement techniques and approaches to inform your practice of integrated health:

1. Very Low
2. Low
3. Moderate
4. High
5. Very High

Are you working primarily as a:

- MD/DO
- Nurse Practitioner/Registered Nurse
- Physician Assistant
- Medical Assistant
- Therapist
- Social Worker
- Care Manager
- QI Manager
- Informatics
- Other

Setting the Stage

Today's key objectives

- Identify characteristics of integrated healthcare within organizations
- Explore the differences between the Quality Improvement (QI) agenda for Behavioral Health and Primary Care
- Describe how Diversity, Equity, and Inclusion (DEI) intersects with integrated health care
- Consider communication variations based on the type of service integration

Why this matters/background/content

Integrated Level Setting

- What are your peer organizations doing?
- What does success look like along the integration spectrum – it will look different and success will be defined differently based on the facility (e.g., hospital, outpatient clinic, BH provider, small practice)
- How do you leverage your expertise in other areas within an integration framework?

Picture Source: https://www.theparliamentmagazine.eu/news/article/integrated-healthcare-from-tipping-point-to-turning-point

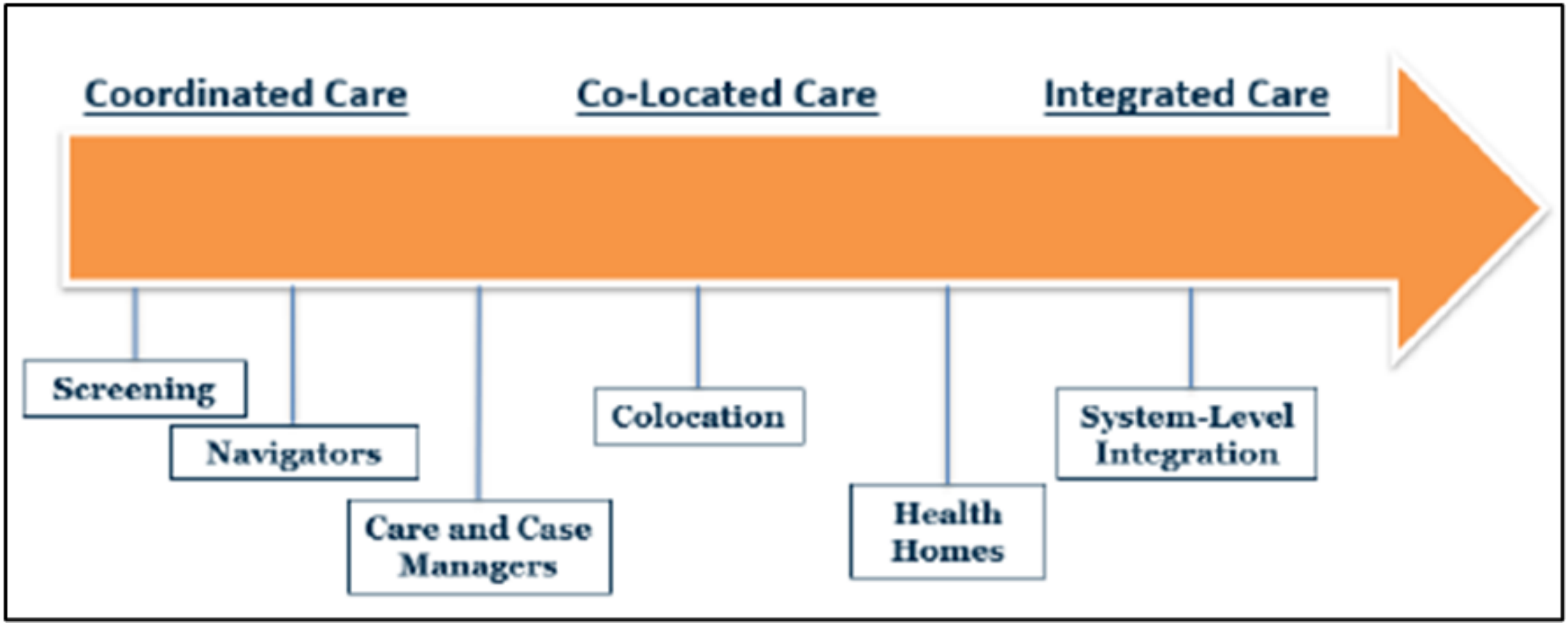
What is Behavioral Health Integration?

- "The care a patient experiences as a result of a **team of Primary Care & 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."

- **What is missing from this?**

Source: C. J. Peek & The National Integration Academy Council's Lexicon for Behavioral Health and Primary Care Integration (2013)

A Spectrum of Integration



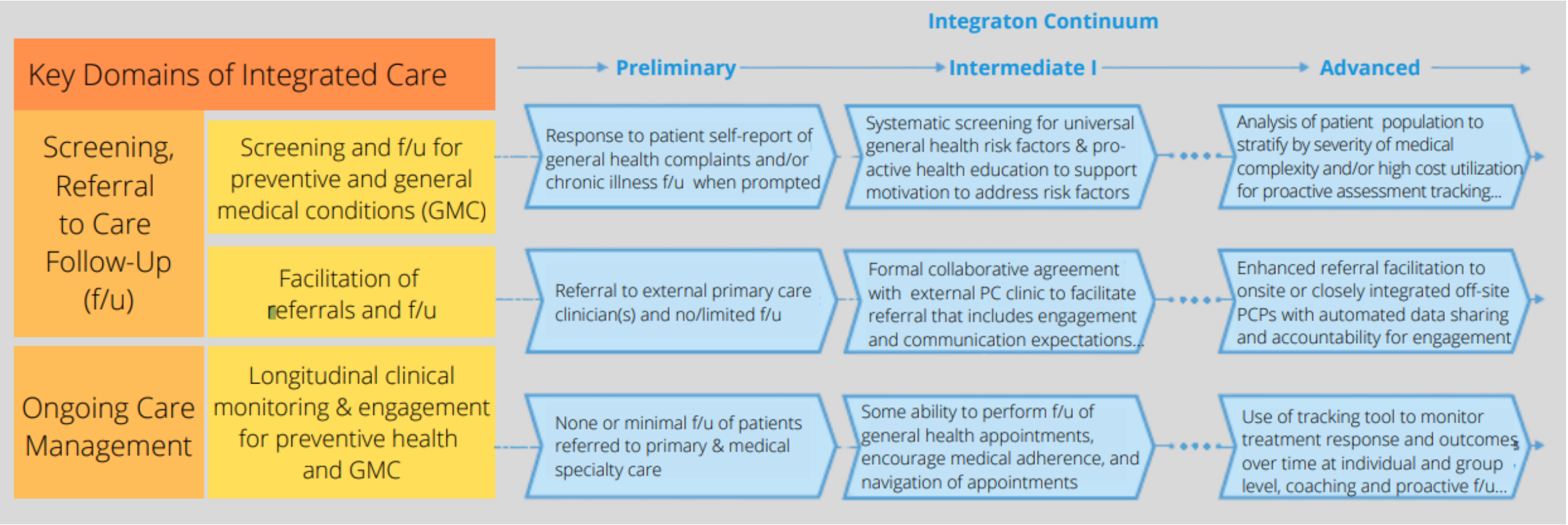
Adapted from: Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund

Poll

What type of integrated healthcare setting is your organization?

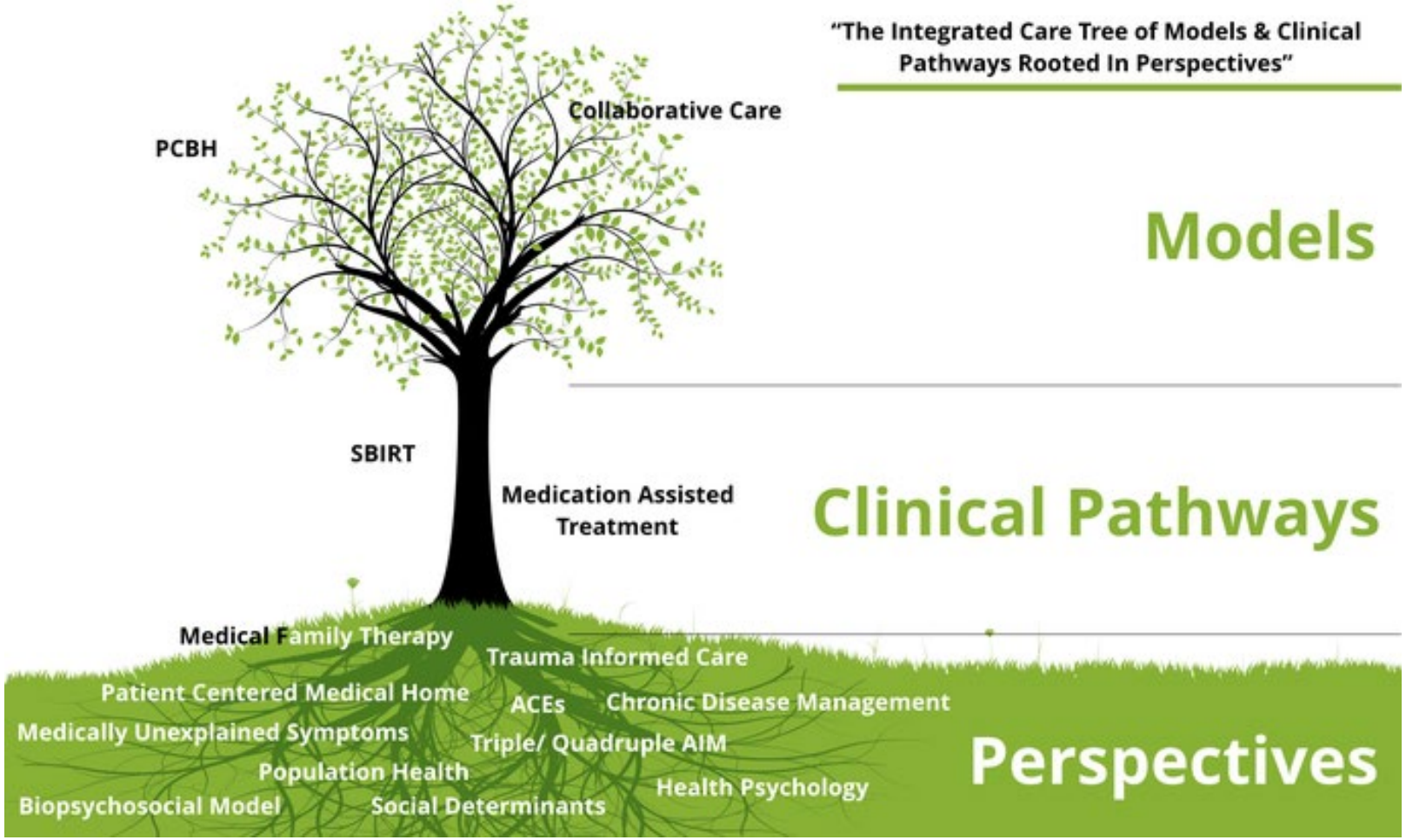
- Coordinated
- Co-located
- Highly Integrated
- None of the above

Integration Continuum



Source: https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?daf=375ateTbd56

Integrated Care Framework

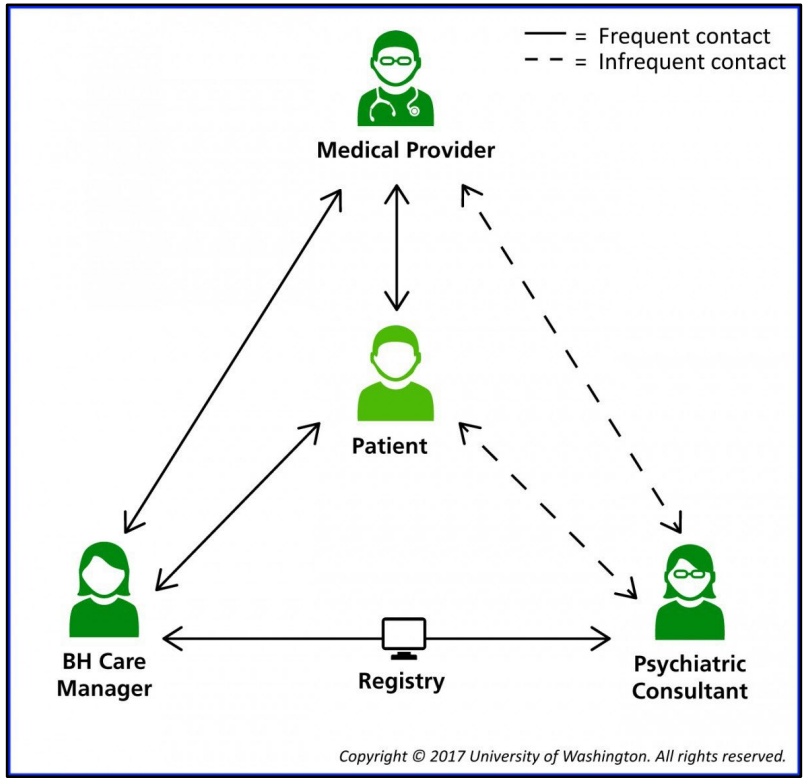


Source: https://www.cfha.net/page/IntegratedCare

Collaborative Care Model (AIMS, IMPACT, CoCM)

Overview

- Focused on specific populations (Typically anxiety and depression)
- Model elements
- Registry-based to track, coordinate care
- “Care manager” delivers brief interventions
- Cognitive Behavioral Therapy (CBT)
- Behavioral Activation (BA)
- Problem Solving Therapy (PST)
- Psychiatric oversight of care manager and PCP
- “Treat to target” w/ standardized outcome tools
- Acknowledgement* by CMS, APA



Goal

- Enhance treatment and management of patients with BH diagnoses efficiently and with frequent touch points

Collaborative Care Model

Strengths:

- Vast array of evidence and research
- Support and recognition by state and federal government
- “Light” staffing requirement

Limitations:

- Limited capacity and scope
- Necessitates psychiatry involvement
- Requires active measurement and data utilization

AIMS Collaboration on BH Integration Resource

Source: https://aims.uw.edu/aims-center-collaborates-behavioral-health-implementation-resource

Primary Care Behavioral Health (PCBH) Model

Overview

- Team-based primary care approach to managing behavioral health condition that adds a Behavioral Health Consultant (BHC) to the team
- BHC is a generalist, typically incorporates elements of health promotion and behavioral medicine
- Brief, solution-focused visits (typically 4)
- Population-wide focus (PCP's population = BHC's population)
- Frequent consultation to PCP and nursing
- High emphasis on open access

Goal

- Enhance the *primary care team's ability* to manage and treat conditions, with resulting improvements in primary care for the entire population

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Primary Care Behavioral Health (PCBH) Model

Advantages:

- Much evidence supporting successful implementation, outcomes, and provider satisfaction
- CMS recognition
- Decreases client management load on PCPs without bifurcating patient
- Significantly increases access to BH services

Disadvantages:

- Lacks built-in emphasis on follow-up tracking
- Not as widely recognized as CoCM (Psychiatric Collaborative Care Model)
- Requires BHC to function in a way unfamiliar to many traditional mental health providers
- More prone to ‘same day billing’ issues depending on provider level
- Open access scheduling management can be a challenge to management

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Blended and Situational Approaches

- Directional
  - Behavioral Health into Physical Health (ED, urgent care, specialty oncology, GI, pain, ID, etc.)
  - Physical Health into Behavioral Health
- Combined CoCM+ PCBH
- Contracting, co-locating, acquisition, single entity
- Whole Health practice

Integrated Care in Practice

Behavioral Health and Primary Care providers **working side-by-side along with other disciplines** (social work, nutrition, pharmacy, others)

Shared health records and care plans: All providers and members of the care management team have access to and document the patient's care in a single medical record

Universal Screenings for common needs (depression, anxiety, substance use) and use of a registry to monitor population needs

Providers accessible for both curbside and in-exam room consults, same day visits (15-30 minute consultation), and prevention education/guidance

Same day and **"warm hand-off"** availability to reduce no-shows and ensure connection to care

Partially adapted from: Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp1-16). N.Y.: Springer Science + Business Media.

Clinical Considerations

Do physical and behavioral health staff collaborate on:

- Chronic disease management (diabetes, recovery, hypertension, depression, asthma)
- Common conditions (insomnia and sleep apnea, chronic pain, cognitive concerns, attentional and behavioral issues in children)

Do physical and behavioral health staff contribute to shared outcomes and measures?

Are clinicians familiar with effective, brief interventions and screenings?

Are there times where a behavioral health provider might see patients instead of the Primary Care Provider (improving access)?

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Operational Considerations

What pathways already exist or need to be developed?

- What do existing population health data indicate is most needed?
  - How is data currently operationalized?

What staffing is available (or convertible, with support)?

- Are certain staff “primed” for integrated care?

Is there efficient passage between service lines?

- Hand-offs (including virtual)?
- Same day/open access?
- Minimal barriers to initial touch point?

Is infrastructure conducive to integration?

Tools and resources

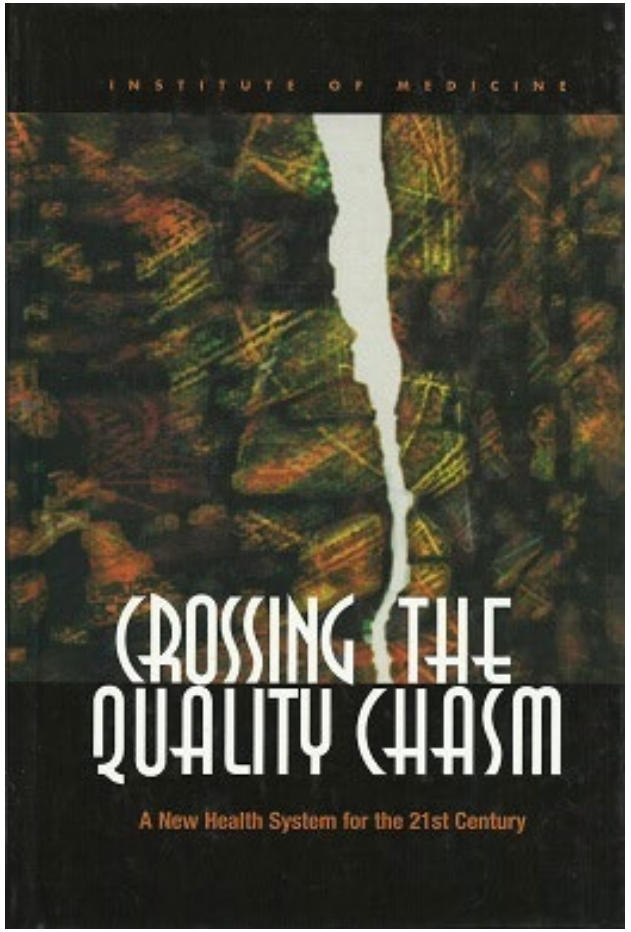
- https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?daf=375ateTbd56
- https://www.cfha.net/page/IntegratedCare
- https://aims.uw.edu/aims-center-collaborates-behavioral-health-implementation-resource

Quality Improvement in Integrated Care

What is Quality Improvement?

Institute of Medicine

"… **improve desired health outcomes for individuals and populations.**" " …care based on the strongest clinical evidence and provided in a technically and culturally competent manner."



Health Care QI - History

1980's

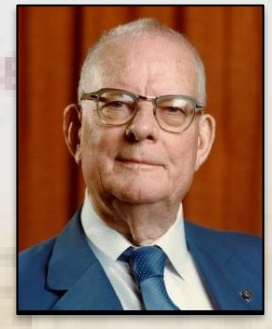
- Lack of QI structure
- QI was contrary to accepted belief
- Healthcare was wasteful, variable, sometimes harmful
- Behavioral healthcare as a discipline had been ignored
- Government Utilization Review focus on documentation and not patient outcomes

https://www.healingmagazine.org/the-evolution-of-quality-improvement-in-behavioral-health-care/

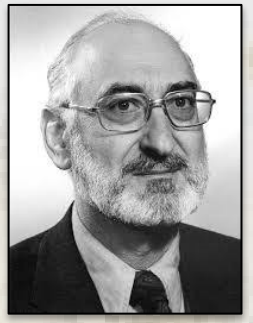
Health Care QI - History

Berwick

Deming



Donabedian



Dr. Berwick - led a national QI demonstration project

- Results fueled the agenda to improve our health care system
- Berwick studied the work of
  - **Dr. W. Edwards Deming-** a statistician & engineer
  - **Dr. Avedis Donabedian -**wrote- "Evaluating the Quality of Medical Care"

Critical Role of Measurement

How do:

- patients know if their healthcare is good care?
- providers know to pinpoint the steps that need to be improved
- insurers and employers determine whether they are paying for the best care that science, skill, and compassion can provide?

https://www.qualityforum.org/Measuring_Performance/ABCs_of_Measurement.aspx

Critical Role of Measurement

- 1990's QI measurement led to mainstream recognition of issues
- QI attracted interest among researchers, policy-makers and the general public
  - 1991-IOM's To Err is Human, NCQA's HEDIS,
  - 2001-IOM's Crossing the Quality Chasm
- Current Industry tools for measurement
  - Certification Commission for HIT- CCHIT
  - Uniform Data System -FQHC's
  - Patient Experience
  - BH-Chart Reviews

Papanicolas & Smith, 2013

The Critical Role of Measurement - BH QI/QA

- 80's and 90's BH QA departments attempted to use Statistical Process Control (SPC) and Total Quality Management (TQM) tools.
  - Both methods failed to make transformative impact, but why?

Lack of skilled staff

Hyper focus on documentation

https://www.healingmagazine.org/the-evolution-of-quality-improvement-in-behavioral-health-care/

Quality Improvement Measure Stewards

Physical Health

EHR reporting capabilities

CMS
HEDIS
NQF
AMA
TJC

Behavioral/Mental/ SUD

- Center for Quality Assessment and Improvement in Mental Health
- American Medical Association - Physician Consortium for Performance Improvement
- Institute for Clinical Systems Improvement
- Maternal and Child Health
- Bureau, Health Resources & Services Administration

Behavioral Health Quality Improvement

- 510 BH measures.
- 1/3 address broad mental health or substance use conditions rather than a specific condition or diagnosis.
- 72% - process measures.
- Data source - administrative claims, few measures rely on EHR or surveys.
- Only 10% or 53 measures have received National Quality Forum (NQF) endorsement.
- Only 5% or 28 unique measures are used in major quality reporting programs.
- Several subdomains of the National Behavioral Health Quality Framework (NBHQF), such as treatment intensification, financial barriers to care, and continuity of care, lack measures that are NQF endorsed.

The Culture of Quality Improvement in Practice - The Struggle is Real

- QI still a struggle for some providers
  - QI programs and mandates are duplicative and confusing
  - Extensive list of endorsed QI measures for physical health
  - Truncated list of QI measures for mental and Behavioral health
- Technology utilization widens the barrier gap
  - Different strengths and challenges when using technology; analytics

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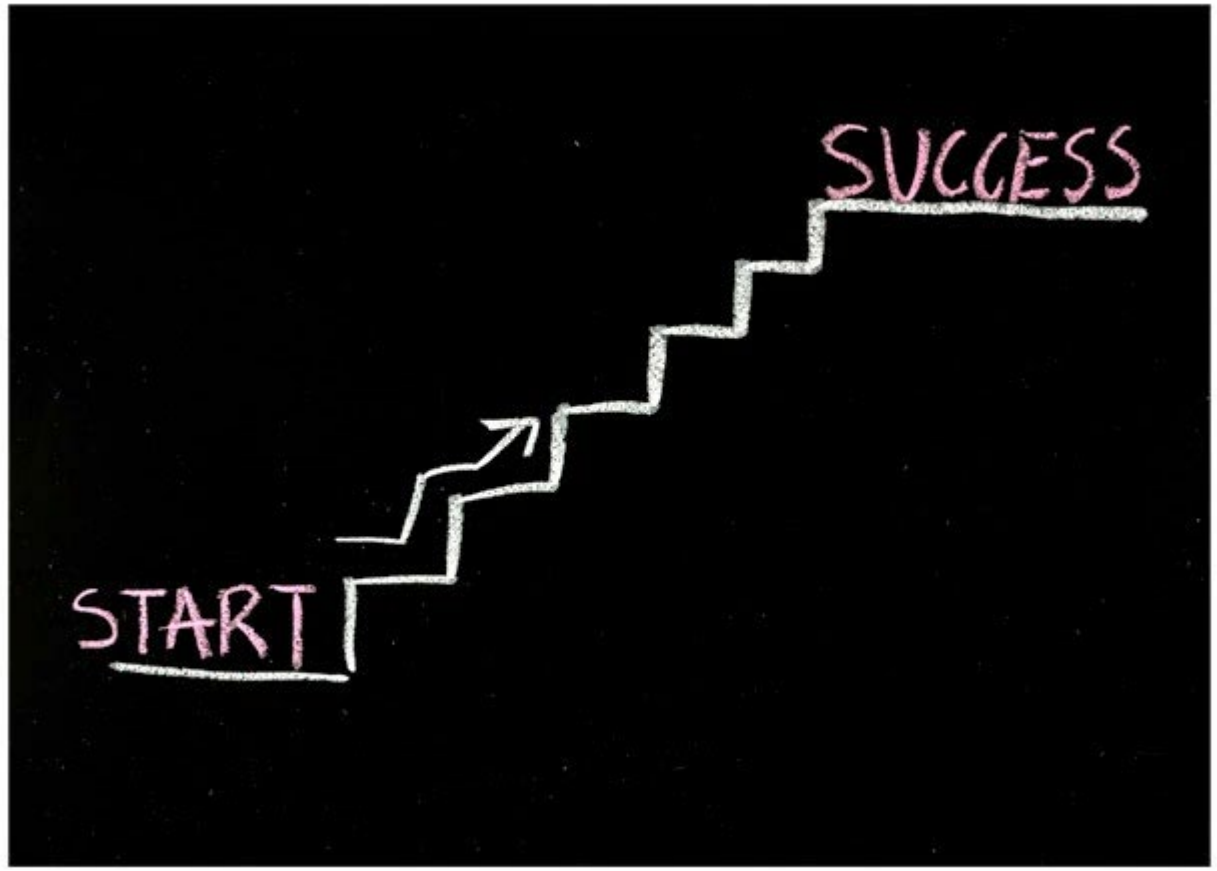
- Feel free to chat us some of your struggles

Successful Intersection of QI for Integrated Care

- The planning
- Executive engagement
- Informed and engaged staff
- QI culture
- Technology that works for Integrated Care delivery
  - Let's stop with the workarounds
  - Unbiased analysis

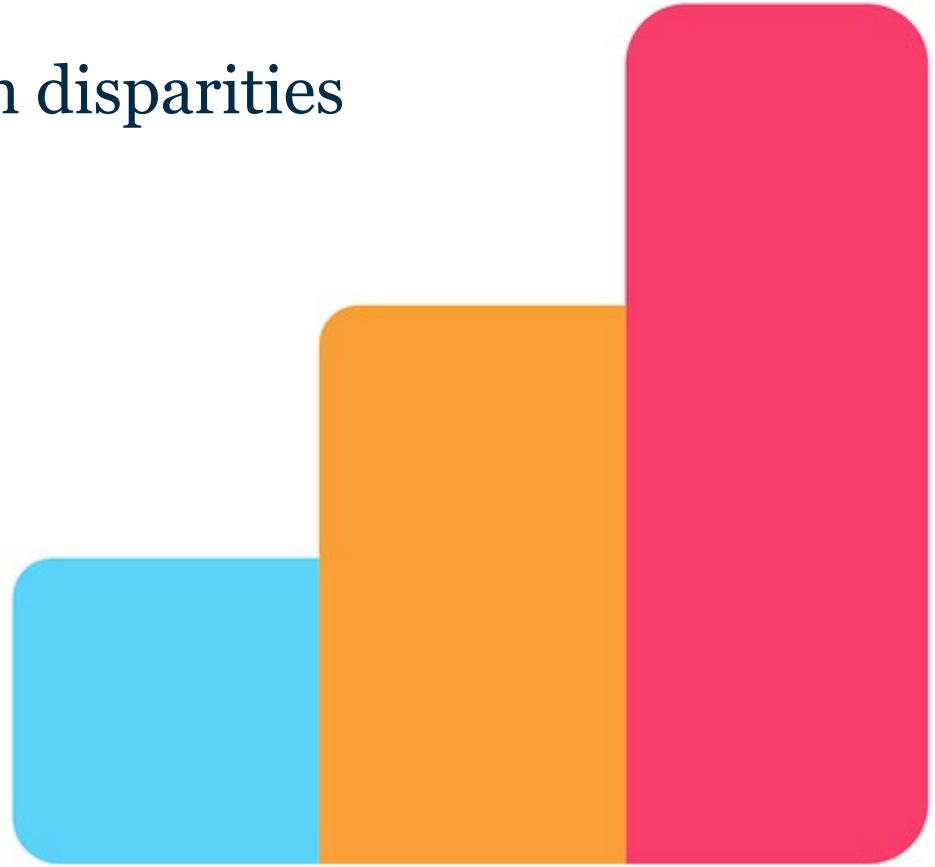


Diversity, Equity and Inclusion Integration

Poll

How comfortable are you talking about health disparities amongst your colleagues at work?

1. Not at all comfortable
2. Slightly comfortable
3. Comfortable
4. Very comfortable
5. Extremely comfortable



Equity in Healthcare

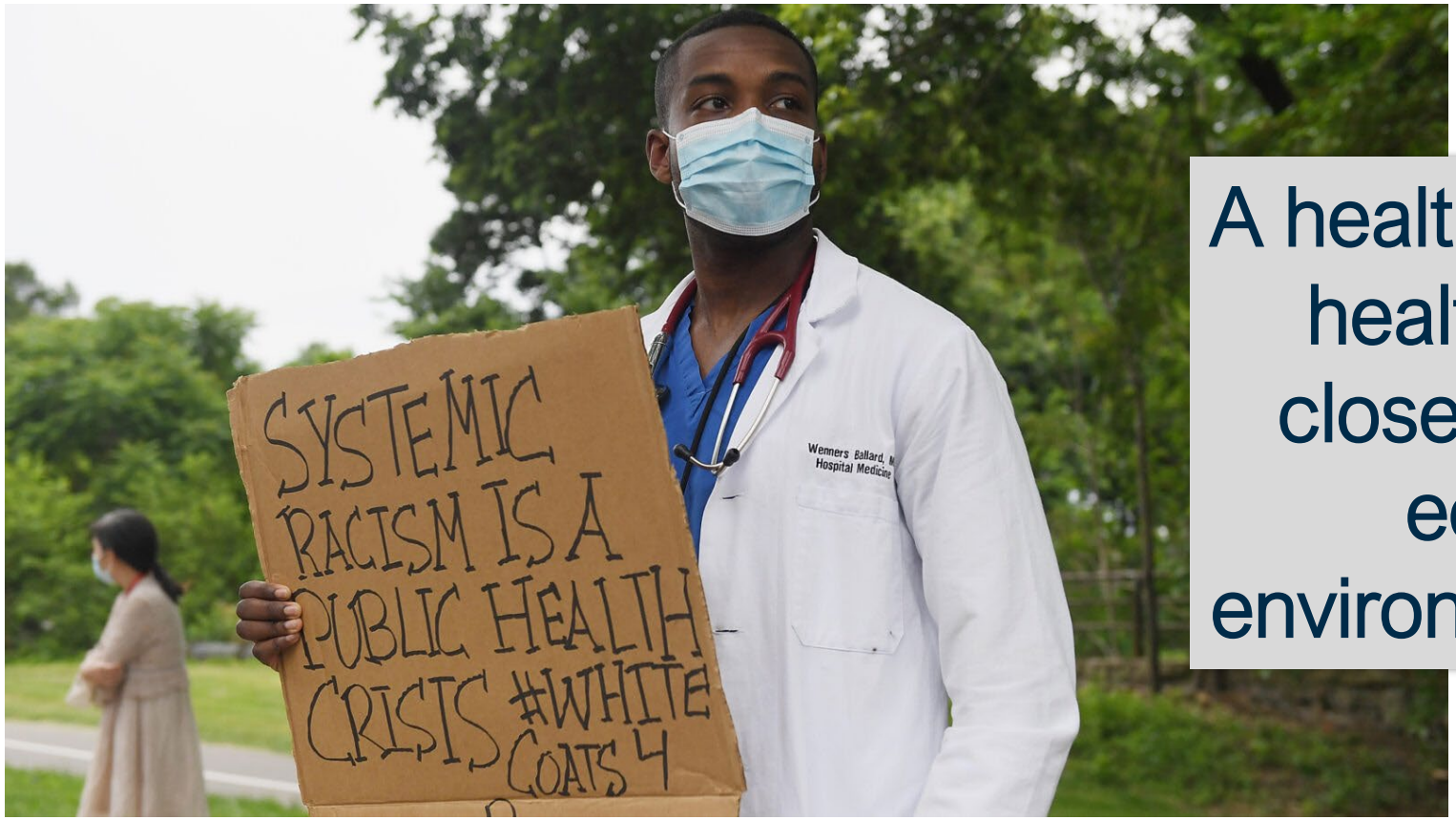
What is Equity?

Provision of care that doesn't vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomics status.

- Access to care varies – having access is not equal to having equitable care

https://www.aamc.org/news-insights/insights/why-health-equity-matters-era-health-care-transformation

Disparities as a Public Health Condition



MICHAEL B. THOMAS/GETTY IMAGES

A health disparity is a type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

https://www.statnews.com/2020/06/09/systemic-racism-black-health-disparities/

Disparities in Mental and Behavioral Health

Reasons why minorities aren't getting proper care:

System weighted towards non-minority values & culture

Individual Beliefs and Stigma

A lack of Availability and Access

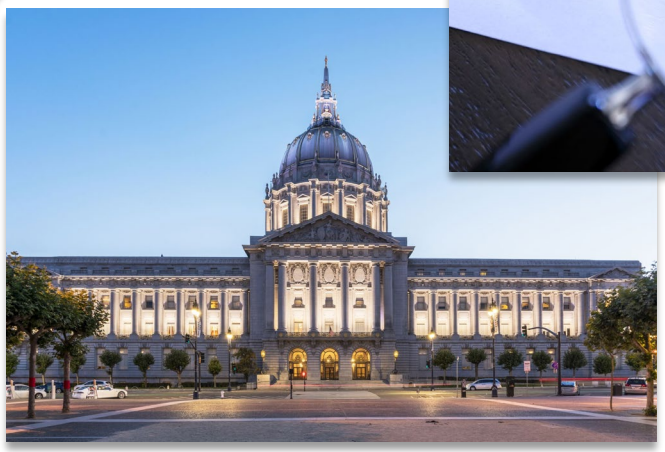
Transportation issues

Language

A lack of adequate health insurance coverage

Disparities in Mental and Behavioral Health

50% of all black and Hispanic adults who entered publicly funded AUD and SUD programs completed those programs, compared with 62% of white patients.



A call to action:

- Legislation
- Culturally competent workforce and services
- Data - collect and track

https://www.ncsl.org/Portals/1/HTML_LargeReports/DisparitiesBehHealth_Final.htm

In Summary: DEI In integrated Care

- Access to services is not equal
  - I don’t want my practice to take on the burden of mental/behavioral health services.
  - I don’t think my patients feel comfortable…
- Stigma is real and shows up in different communities in various ways
  - We don’t need head doctors; you just need church.
- Stigma is real from providers
  - Cultural and religious influences impact access to integrated care.

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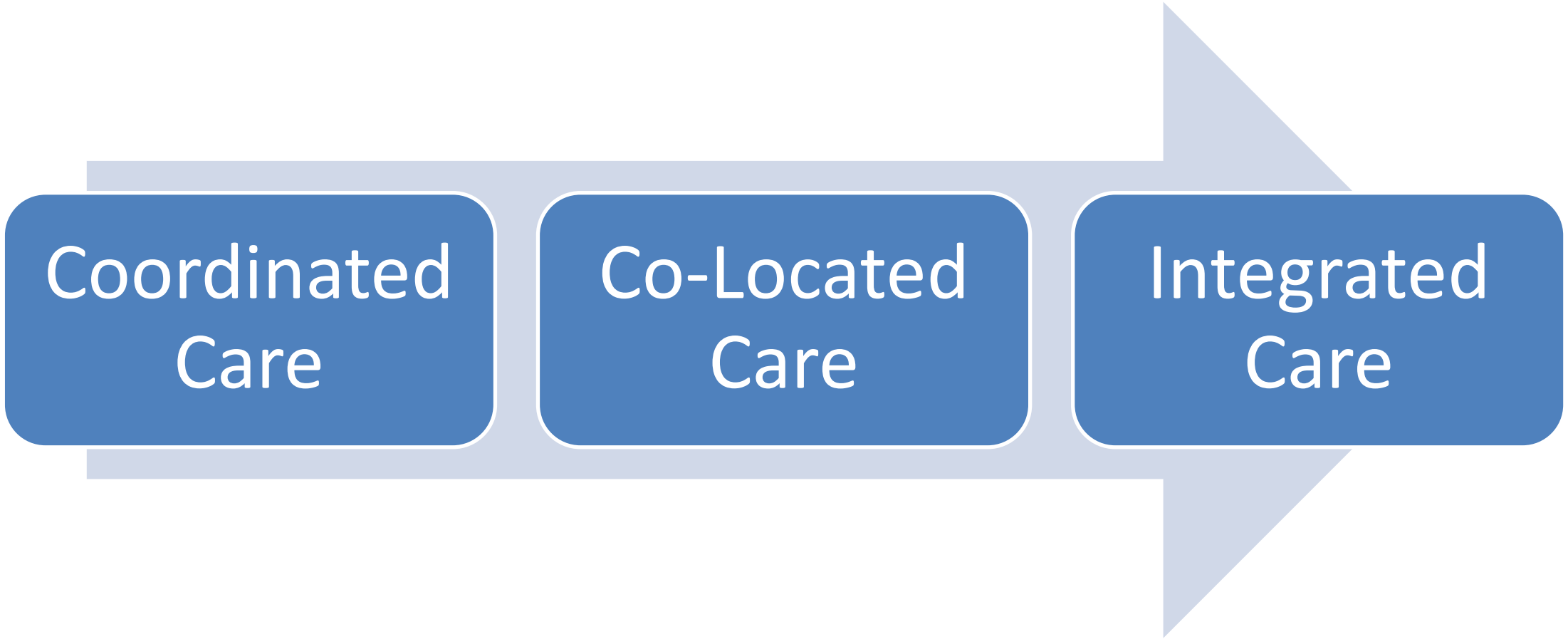
Communication and Integrated Care



Coordinated Care

- Technology:
  - Separate systems - communication is facilitated by phone, secure email, fax, etc.
- Coordination of Care:
  - May include a Memorandum of Understanding (MOU) in place to facilitate sharing
  - Providers need to specify communication expectations
    - Frequency
    - Type of information
- Consent:
  - Both parties must obtain consent from patient to meet HIPAA requirements

Co-Located Care

- Technology:
  - May or may not be on the same IT systems
- Coordination of Care:
  - May need MOU in place to facilitate sharing
  - Fewer access barriers may result in more direct communication between providers
  - Providers need to specify communication expectations between providers
    - Huddles related to individual patient care
    - Sharing of care plans and other clinical information
- Consent:
  - Both parties may still need to obtain consent from patient to meet HIPAA requirements

Integrated Care

- Technology:
  - May be on the same IT system (though not always!)
- Coordination of Care:
  - Need to specify communication expectations between providers/care team within practice policies and procedures
    - Huddles related to individual patient care
    - Warm hand-off
    - Sharing of care plans and other clinical information
- Consent:
  - The practice may still need to obtain patient consent to meet HIPAA requirements

PHI Challenges to Integration

Integrated care requires healthcare data sharing to:

- Avoid medication errors
- Decrease duplicate testing
- Allow multi-disciplinary input on patient care plans
- Facilitate robust population health management

Current limitations on data sharing but significant movement to allow for greater interoperability

Communication with Patients

- Communicating the need for consent to share health information between clinicians
  - Many patients do not understand the restrictions to sharing patient health information (PHI)
- All staff, particularly registration staff, must communicate the need for consent
  - Train staff in motivational interviewing techniques for all levels of staff
    - Plain language, OARS, etc.
  - Develop tools and scripts to aid the conversation
  - Monitor consent rates and share data with staff

Today's key takeaways

- Identify ways to support successful integrated healthcare within organizations
- Understand the history to inform a future integrated Quality Improvement agenda
- Understand how Diversity, Equity, and Inclusion can help build a more informed integrated delivery system
- Acknowledge differences in communication based on degree of integration and address them within health center processes and staff training

Poll

After attending this webinar, please rate your skills and comfort with applying quality improvement techniques and approaches to inform your practice of integrated health:

1. Very Low
2. Low
3. Moderate
4. High
5. Very High

Office Hour

Upcoming Center of Excellence Events:

CoE Webinar: Building Capacity in the Integrated Health Workforce: A focus on Substance Use Education
Register for the webinar on Tuesday, November 2, 3-4pm ET

CoE Office Hour: Building Capacity in the Workforce: A focus on Substance Use Education
Register for the office hour on Thursday, November 4, 3-4pm ET

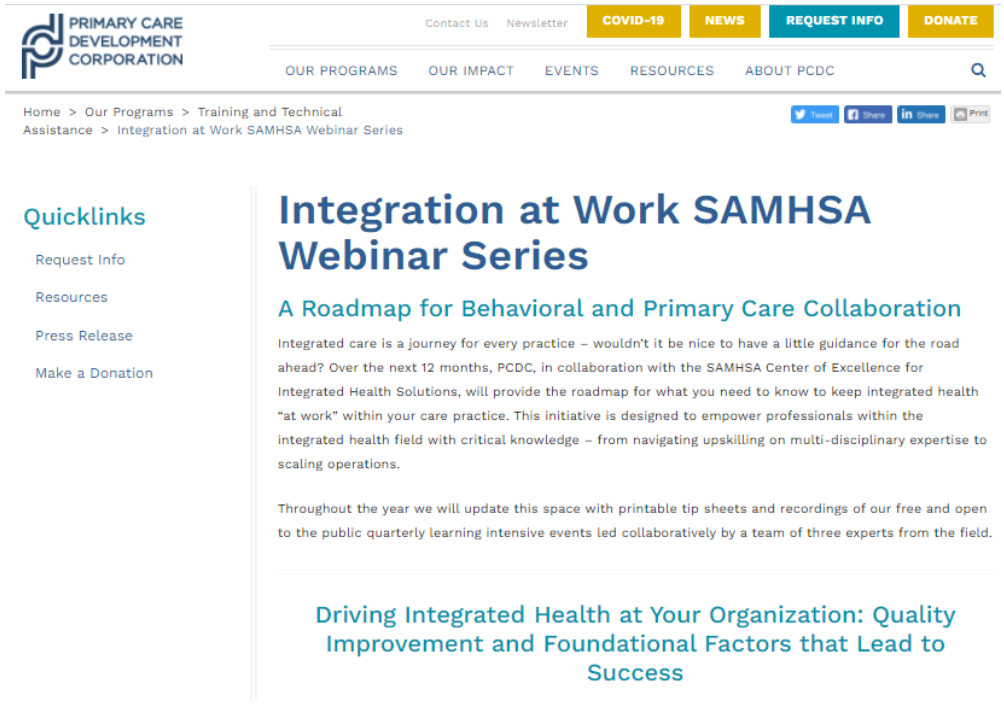
University of South Alabama (USA) ECHO: Substance Use Disorder (SUD) teleECHOTM
Register for the ECHO series launching on Tuesday, November 9, 1-2:30pm ET

CoE Office Hour: November Health Equity/BIPOC - Part 1
Register for the office hour on Monday, November 15, 2-3pm ET

CoE ECHO: Advancing Rural Health Equity through Integrated Care ECHO
Register for the ECHO series launching on Wednesday, November 17, 11:30am-1pm ET

CoE Office Hour: November Health Equity/BIPOC - Part 2
Register for the office hour on Thursday, November 18, 2-3pm ET

Contact Us



Clinical & Quality Partners

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Visit pcdc.org/integration to learn more about the series!