PRIMARY CARE DEVELOPMENT CORPORATION

CENTER OF EXCELLENCE for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

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Quality Improvement Tips for Integrated Care Settings

Types of Integration

Coordinated Care (off-site)

Level 1: Minimal Collaboration

Patients are referred to a provider at another practice site, and providers have minimal communication

Level 2: Basic Collaboration

Providers at separate sites periodically communicate about shared patients

Co-located Care (on-site)

Level 3: Basic Collaboration

Providers share the same facility, but maintain separate cultures and develop separate treatment plans for patients

Level 4: Close Collaboration

Providers share records and some system integration

Highly Integrated Care

Level 5: Close Collaboration

Providers develop and implement collaborative treatment planning for shared patients but not for other patients

Level 6: Full Collaboration

Providers develop and implement collaborative treatment planning for all patients

Integration Continuum

Key Domains of Integrated Care		Preliminary	Intermediate I	Advanced
Screening, Referral to Care Follow-Up (f/u)	Screening and f/u for preventive and general medical conditions (GMC)	Response to patient self-report of general health complaints and/or chronic illness f/u when prompted.	Systematic screening for universal general health risk factors & proactive health education to support motivation to address risk factors.	Analysis of patient population to stratify by severity of medical complexity and/or high-cost utilization for proactive assessment tracking.
	Facilitation of referrals and f/u	Referral to external primary care clinical(s) and no/limited f/u.	Formal collaborative agreement with external PC clinic to facilitate referral that includes engagement and communication expectations.	Enhanced referral facilitation to onsite or closely integrated off-site PCPs with automated data sharing and accountability for engagement.
Ongoing Care Management	Longitudinal clinical monitoring & engagement for preventive health and GMC	None or minimal f/u of patients referral to primary & medical specialty care.	Some ability to perform f/u of general health appointments, encourage medical adherence, and navigation of appointments.	Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u.

Overcoming Data Sharing Challenges

Facilitate robust population health management (PHM). Celebrate ways PHM highlights organizational impact and new ways to improve care.

Allow multi-disciplinary input on patient care plans through structured meetings and creating a culture of collaboration.

Decrease duplicate testing.

Coach staff to identify the individual role they can play in avoiding medication errors.

QI Considerations for Integrated Settings Checklist

- Physical and behavioral health staff collaborate on chronic disease management AND common conditions.
- Physical and behavioral health staff all contribute to shared outcomes and measures.
- Clinicians are familiar with effective, brief interventions and screenings.
- Population health data is reviewed regularly to determine what services are necessary.
- Key staff are prepared to successfully support integrated care.
- Warm and efficient patient hand-offs are provided between service lines. (both virtual and in-person)
- Barriers for patients to see an initial provider are minimized. (i.e. same day appointment availability)
- Physical space designed in a way that facilitates integration.

Bringing It All Together

Look for Opportunities for Improvement:

- Do patients understand the restrictions and protections regarding sharing of their patient health information (PHI)?
- Are all levels of staff provided with upskilling on motivational interviewing techniques?
- What tools, trainings or scripts are available to aid with difficult conversations?
- How regularly are consent rates monitored and data shared broadly with all involved staff members?

Support Best Practices:

- Earn buy in from all staff on the value of patient consents and collecting PHI
- Build trust with patients by clearly communicating what consents for PHI are and how PHI is used

Stability and success for your integrated care setting!

- Stronger data and tracking give the ability to celebrate organizational and staff "wins"
- More informed retention and recruitment efforts
- Positioned for funding opportunities
- Building trust

Contact us to discuss how our services can help your care teams.

Email: cqp@pcdc.org

This resource was developed in partnership with the Center of Excellence for Integrated Health Solutions with acknowledgments to Amy G. Breyer, Deborah Johnson Ingram, Maia Morse, and Kimberly Mirabella.

Sources:

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

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